

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH06825  
REG. NO.1 - STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>Mr. William Leroy Ebelein</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 12 1984</b>			2b. HOUR <b>A.M.</b>		
1. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 16 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3810 Gwynn Oak Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shipping clerk</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William George Ebelein</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna R. Roberson</b>		13e. STREET ADDRESS / ZIP CODE <b>3810 Gwynn Oak Ave. 21207</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>unknown</b>		17. INFORMANT <b>Mrs. Grace Hipsley</b>		ADDRESS <b>21228 Catonsville Maryland</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CEREBROVASCULAR ACCIDENT**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

any, which  
immediate  
stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

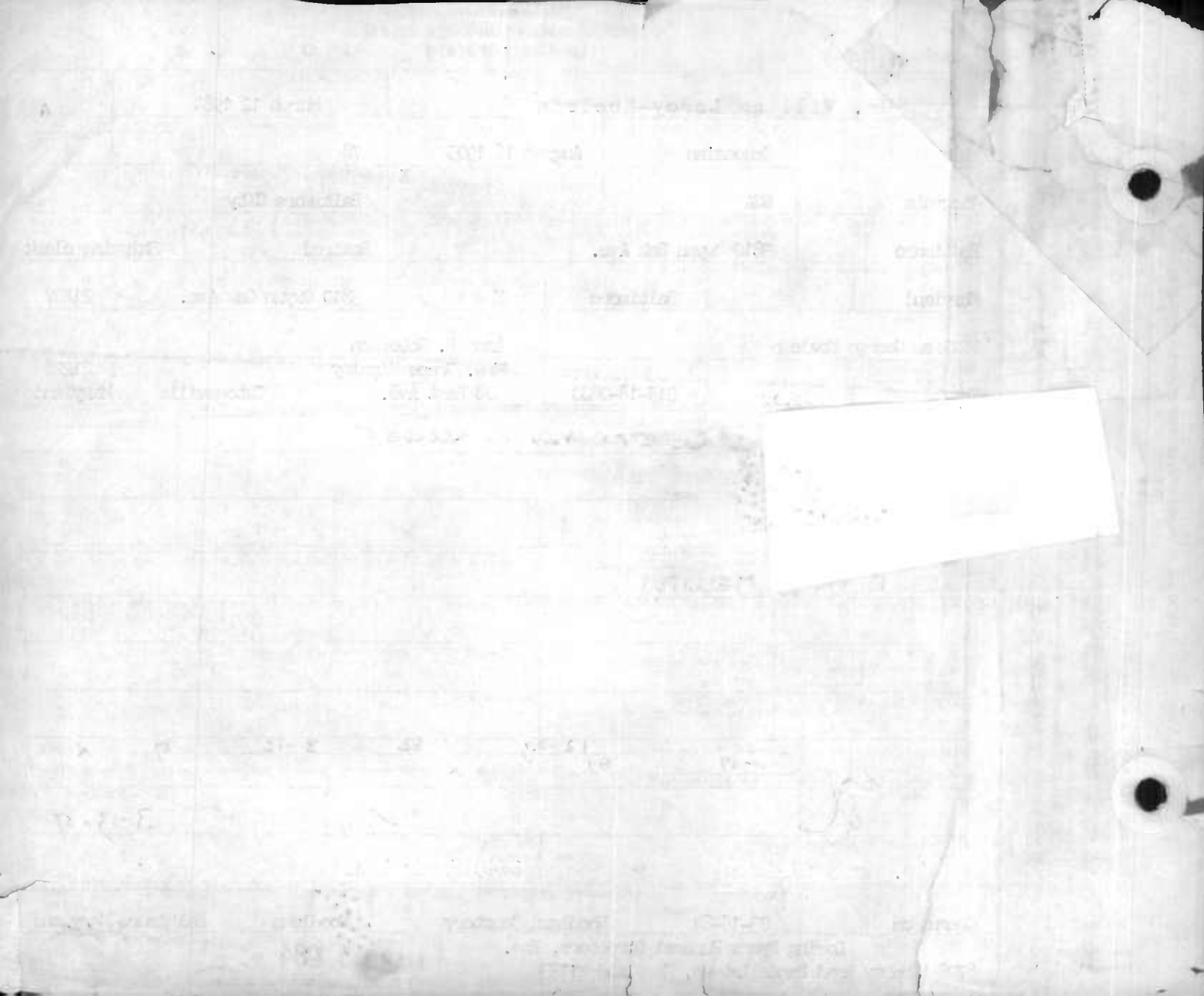
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

**DIMETES MELLITUS**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> , 19 <b>82</b> , to <b>3-12</b> , 19 <b>84</b> , that <b>X</b> (we) lost saw the deceased alive on <b>1-17</b> , 19 <b>84</b> , and that in (my) <b>X</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>X</b> (we) did not view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-13-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Arthur Lebson</b>				22e. ADDRESS <b>3640 Fords Lane</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>03-16-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>			





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR <b>ALTON JOHN ECKERT</b>							
1. DECEASED NAME (TYPE OR PRINT) <b>ALTON JOHN ECKERT</b>				2a. DATE OF DEATH MONTH <b>3</b> DAY <b>13</b> YEAR <b>89</b> 2b. HOUR <b>5<sup>25</sup> AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>8</b> YEAR <b>22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MACHINIST</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1401 DUNDALK AVE 21222</b>	
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>JULIAN</b> LAST <b>ECKERT</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b></b> LAST <b>BALK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W.W. II 219.05.8370</b>		17. INFORMANT ADDRESS <b>BELIA L. ECKERT SAME AS 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Respiratory Failure</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Exudative pleural effusion of undetermined cause.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 12, 19 89</b> , to <b>March 13, 19 89</b> , that (I) (we) last saw the deceased alive on <b>March 13, 19 89</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. S. E. Valone</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. E. VALONE</b>				22e. ADDRESS <b>BCH</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/15/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE,</b> COUNTY <b></b> STATE <b>MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>WALTER BROOKS BRADLEY, INC.</b> ADDRESS <b>DUNDALK, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Mondell</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06827

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM HENRY EDISON</b>			7a. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>2</b> YEAR <b>1984</b>			7b. HOUR <b>7<sup>00</sup></b> AM	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>18</b> YEAR <b>21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GREENVILLE, NORTH CAR.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMP.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE <b>2501 SHIRLEY AVE. 21215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>220-14-1514</b>		17. INFORMANT ADDRESS <b>BERNARD WELLS 1014 EDMONDSON AVE. 21217</b>			

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**1629**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>2600 Liberty Hgts</b> CITY OR TOWN <b>Liberty Hgts</b> COUNTY <b>MD.</b> STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> , 19 <b>84</b> , to <b>3/2</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W. Royal, MD</b>				DEGREE		22c. DATE SIGNED <b>3/2/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. ROYAL III, MD</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/6/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOR. VET. CEM.</b>		23d. LOCATION CITY OR TOWN <b>REISTERSTOWN, MD.</b> COUNTY <b>MD.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1984</b> REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George H. EDLER			2a. DATE OF DEATH March 11, 1984			2b. HOUR 12:20am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 18, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Operator		12b. KIND OF BUSINESS OR INDUSTRY Steel Mfg.	
13a. STATE Md.			13b. CITY OR TOWN Dundalk		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 101 Willow Spring Rd. 21222		
14. FATHER'S NAME John Henry Edler			15. MOTHER'S MAIDEN NAME Margaret Doerfler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II-Korea 218.09.9302		17. INFORMANT Sharon M. Reed 5111 Fait Avenue Baltimore, Md. 21224				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>Abdominal Aortic Aneurysm</del> Myocardial Infarction Arrest 4414 DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
19a. DATE OF OPERATION March 7, 1984			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aortic Aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (TYPE OF MEDICAL EXAMINER) March 7			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (b) (this hospital) attended the deceased from March 1, 1984, to March 11, 1984, that (b) (we) lost saw the deceased alive on March 11, 1984, and that in my opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE M. Bijpuria M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Bijpuria M.D.						22e. ADDRESS Church Hospital 21231 100 North Broadway Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/13/1984		23c. NAME OF CEMETERY OR CREMATORY Gds of Faith Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rose Dale Balto. Md.		
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc., Dundalk Md. 21222						25a. DATE REC'D. BY REGISTRAR MAR 13 1984		25b. REGISTRAR'S SIGNATURE	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6 8 2 9		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles Edwards</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>3-11 19 84</b>		2b. HOUR M <b>9:17 a. M</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 44</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>39 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>39</b>	IF UNDER 24 HRS. HOURS MIN <b>39</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3-14 19 84</b>		2d. HOUR M <b>9:17 a. M</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1900 blk. Thames St. (harbor)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21213 1409 N. Washington St.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clifton Edwards</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Inetha Wade</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. <b>219-42-5352</b>		17. INFORMANT ADDRESS <b>Inetha Edwards 2106 E. Biddle St.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9/108 Drowning</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>est. ? P.M. 3-11 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject recovered from water</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1900 blk. Thames St., Balto., Md.</b>						
22a. I certify that Hook charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) <b>Assistant MEDICAL EXAMINER</b>				DATE SIGNED <b>3-14-84</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARbutus Mem Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc, 1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Dawson-Robert</i>				

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 8 3 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MITCHELL</b>			FIRST MIDDLE LAST <b>EISENBERG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 10-84</b>			2b. HOUR <b>1152 AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>XX XX XXXX 18 1897</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>XX 86 YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>XXXXX POLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO City</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTO</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHWAI Hosp of BALTO.</b>			12a. USUAL OCCUPATION (TYPE OF BUSINESS, POST OF WORKING LIFE) <b>XXXXXXXXXXXX</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BOARDING HOUSE</b>		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS <b>APT. 2nd FLOOR 21215 4101 Park Height Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>MENDEL EISENBERG</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETHEL NIZINSKY</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-16-4125</b>		
17. INFORMATION STATE OF MICHIGAN <b>CHARLES YUMKAS</b>			17. INFORMATION STATE OF MICHIGAN <b>CHARLES YUMKAS</b>			17. INFORMATION STATE OF MICHIGAN <b>CHARLES YUMKAS</b>			17. INFORMATION STATE OF MICHIGAN <b>CHARLES YUMKAS</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <b>Resp Failure / CHF / R.F.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
0389			DUE TO, OR AS A CONSEQUENCE OF			(b) <b>Sepsis</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF			(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> 19 <b>84</b> to <b>3/10</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edward Franco</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/10/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD FRANCO</b>			22e. ADDRESS <b>SHWAI Hosp of Baltimore</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/11/84</b>			23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI ZION CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>			24b. ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified of this.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD ELIASON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 10 84</b>		2b. HOUR <b>804 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>CAU.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 19 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hosp of Balto</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTERS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN ELIASON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HENRIETTA JORDON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-10-8879</b>		17. INFORMANT <b>MRS. SARAH ELIASON</b> <b>5722 OAKSHIRE RD. BALTO. MD., 21209</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST / RESPIRATORY ARREST</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>84 3/8 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) <b>3/10 84</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>84 3/10 84</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/10 84</b> to <b>3/10 84</b> , that (I) (we) last saw the deceased alive on <b>3/10 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edward</b>		DEGREE		22c. DATE SIGNED <b>3/10/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD FRANK</b>		22e. ADDRESS <b>Sinai Hosp of Balto</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 13, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 06832	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) <b>MAURICE WM ELLIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 13 84</b>		2b. HOUR <b>5P</b> M	
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>02 11 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1230 W MOS HET ST 21217</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILBERT ELLIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OTELIA JONES (Silverman)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>216-24944</b>		17. INFORMANT ADDRESS <b>Mildred Waters 1173 E. Northern Pkwy.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> <b>5723</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hemorrhage</b> (c) <b>ESOPHAGEAL VARICES</b> DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.						
19a. DATE OF OPERATION <b>13 March 84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PORTAL HYPERTENSION</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>12 March 1984</b> to <b>13 March 1984</b> , that (I) (we) last saw the deceased alive on <b>13 March 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>13 March 84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD J Doolin</b>		22e. ADDRESS <b>22 S. Greene ST BALTO MD</b>				
23a. BURIAL, CREMATION, REMOVAL (S) <b>BURIAL</b>	23b. DATE <b>3/17/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>		ADDRESS <b>1101 E North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Felia Davidson-Rendell</b>		

MEDICAL CERTIFICATION



8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PEND NG" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		6 8 3 3																					
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH		2b. HOUR											
Robert Ensley										3 25 84		M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR									
Male		White		8 7 23		60 YRS.		MONTHS DAYS		HOURS MIN.		3 25 84		7:50 a M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Washington State				U.S.A.								Baltimore City, MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore				2703 Miles Avenue				Truck Driver															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Md.								Balto.				YES <input type="checkbox"/> NO <input type="checkbox"/>				2701 Miles Ave. 21211							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																	
Dewey Richard Ensley						Esther Colwell																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS											
Yes						WWII						218-16-5406						Mrs. Dorothy Ensley Balto., Md. 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED											
Dennis F. Smyth, M.D.				Assistant MEDICAL EXAMINER								3/25/84											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Dennis F. Smyth, M.D.				111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Removal				3/27/84																			
24. FUNERAL DIRECTOR NAME												25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Anatomy Board Balto., Md.												MAR 28 1984				Asha Davidson-Randall							

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



RECEIVED  
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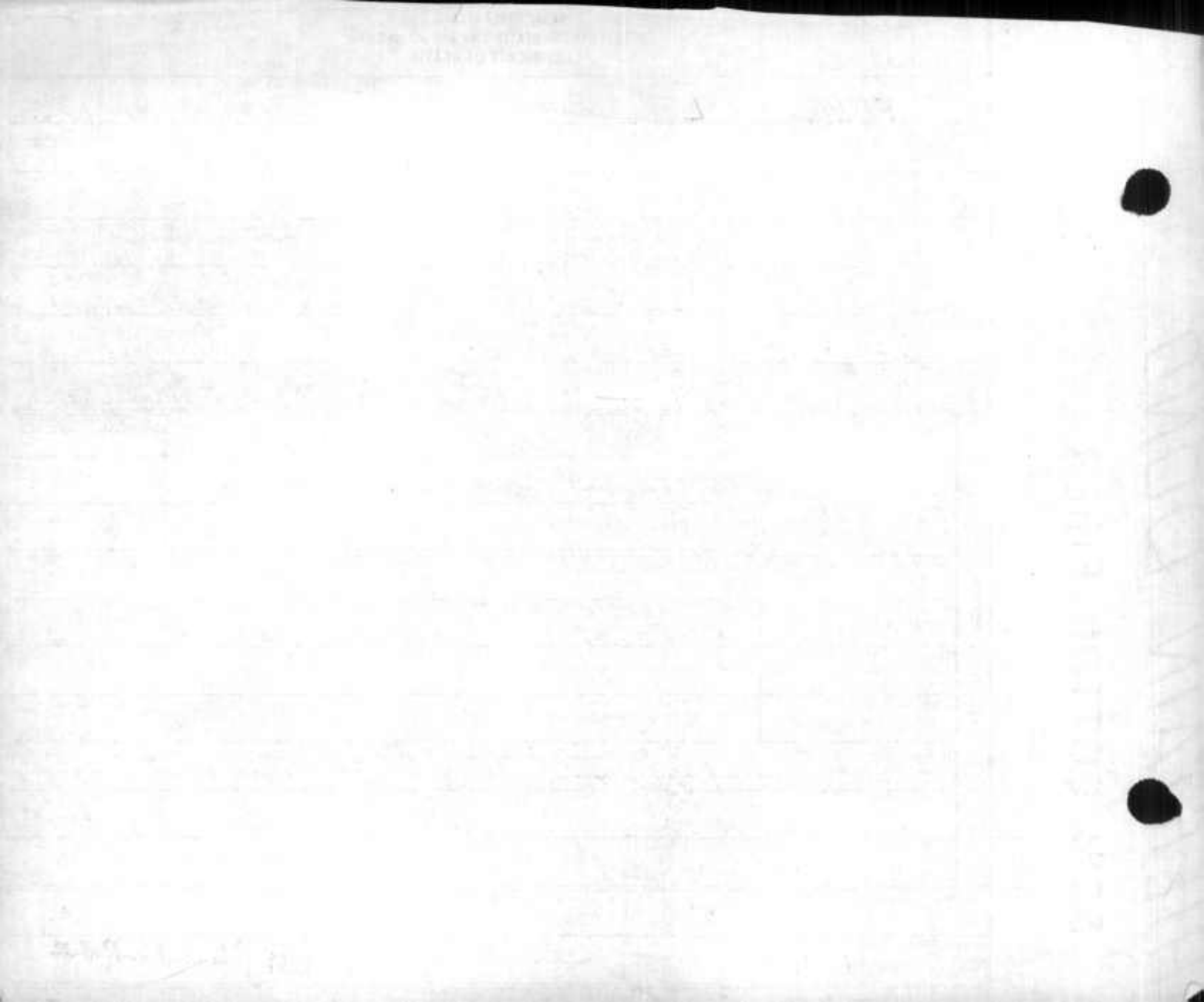
OFFICE OF THE  
DIRECTOR

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William L. Epps</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>31</b> YEAR <b>1984</b>			2b. HOUR <b>1:13</b> M				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>19</b> YEAR <b>1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Providence Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13b. STREET ADDRESS <b>1618 Thomas Ave.</b>			21216				
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Bradley</b> LAST <b>Epps</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE <b>Epps</b> LAST <b>Epps</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>245-07-3398</b>			17. INFORMANT <b>Richard Epps</b> ADDRESS <b>2323 E Fayette St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4422</b> IMMEDIATE CAUSE (a) <b>IRREVERSIBLE HEMORRHAGICS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>RUPURED LEFT INTRACRANIAL ARTERY ANEURYSM.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <b>3-31-84</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RUPURED ANEURYSM WITH SHOCK</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>PM 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/31/1984</b> to <b>3/31/1984</b> that (I) (we) last saw the deceased alive on <b>3/31/1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>GARTH A.S. SAMUELS</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/31/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARTH A.S. SAMUELS</b>						22e. ADDRESS <b>6911 PARK HEIGHTS AVE.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>4/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 4 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

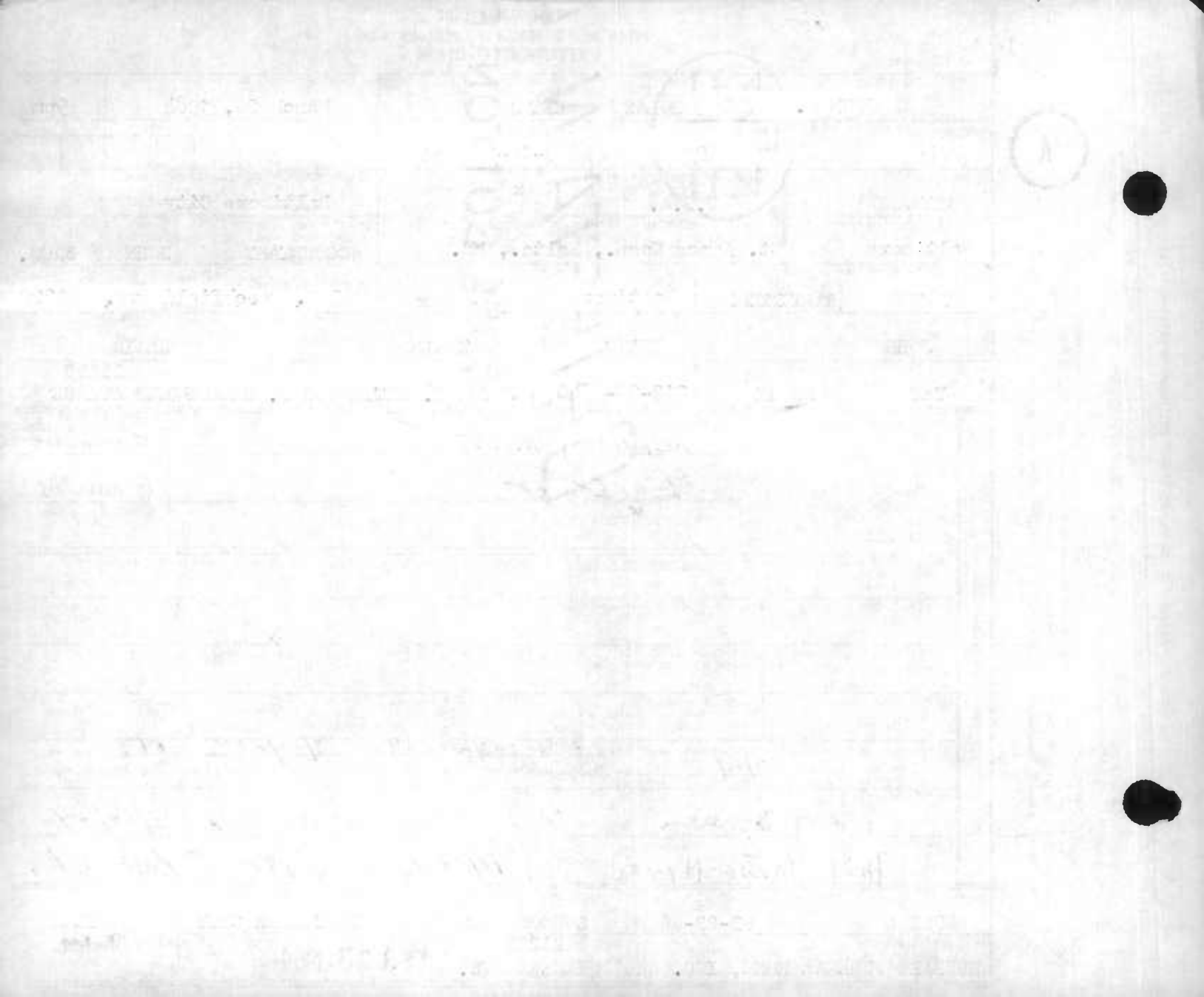
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 8 3 5

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN NICHOLAS ERTTEL		2a. DATE OF DEATH MONTH DAY YEAR March 20, 1984	
3. SEX MALE		4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR 09 16 26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp., Balto., Md.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY JOHNSON BROS.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ARBUTUS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ERTTEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THELMA BLAIR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 212-20-5540	
17. INFORMANT ADDRESS 21229		JOYCE V. ERTTEL 903 S. BEECHFIELD AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8:45 PM 3/20</u> 19 <u>84</u> , to <u>3/20/84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Paul Young-Hyman</u>		22c. DATE SIGNED 3/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Young-Hyman		22e. ADDRESS 1409 William Street Balto. MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-23-84	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		25. DATE REC'D. BY REGISTRAR FEB 23 1984	
ADDRESS 4107 WILKENS AVE.		REGISTRAR'S SIGNATURE <u>John Harrison</u>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 6 8 3 6

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SOPHIA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 / 18 / 84</b>			2b. HOUR <b>6:35 P.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 13 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS				
7a. BIRTHPLACE COUNTRY <b>HUNGARY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General</b>				12a. USUAL OCCUPATION (STUDENT WORKER FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>DORCHESTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>3202 ELIZABETH AVENUE, 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN LEFORT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-74-0088</b>		17. INFORMANT ADDRESS <b>EDGEWATER, MARYLAND 21037</b> <b>FREDERICK P. ESS 3490 S. RIVER TERRACE</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>84</b> , to <b>3/18</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>3/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.										
22b. SIGNATURE <b>Paul S. Herman, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/18/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul S. Herman</b>			22e. ADDRESS <b>3001 S. Hanover</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>03-22-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>						ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>		
25b. REGISTRAR'S SIGNATURE <b>Kia Davidson-Randall</b>										

MEDICAL CERTIFICATION

3/11/22

John C. ...

John C. ...

...

...

...

John C. ... 3/11/22

John C. ...

John C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06831			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 24 84			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY ARET JEAN ETZEL				2b. HOUR 730 AM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 09 29 33		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY SOL. SEC.	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ETZEL SR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA ETZEL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-30-5236	
17. INFORMANT ADDRESS ABOVE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 3, 1984, to March 24, 1984, that (I) (we) lost saw the deceased alive on March 24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph M. Reilly MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Reilly		22e. ADDRESS Univ. of Md Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/27/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME J. G. CONNELLY		ADDRESS 300 MACC		25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rodgers	

BP



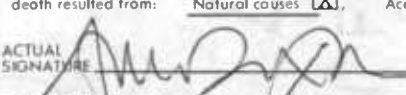
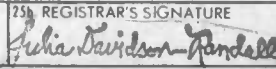


DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 8 3 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BEN FRANK EVANS			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 19 1984			2b. HOUR M 9:46 PM		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 27 27	6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 19 1984	7d. HOUR M 9:46 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 N. Dallas Ct.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sam Evans			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phenie Reed			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16a. SOCIAL SECURITY NO. 238-44-9528			17. INFORMANT ADDRESS William Evans 209 N. Dallas Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive &amp; arteriosclerotic cardiovascular disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 3-20-84		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (S) BURIAL		23b. DATE 3/24/84		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR MAR 23 1984		25b. REGISTRAR'S SIGNATURE 		

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

RECEIVED

NOV 19 1964



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06839

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles John EVANS			2a. DATE OF DEATH MONTH DAY YEAR March 23, 1984		2b. HOUR 12 45 M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 31, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S. U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF SUCH FACILITY, GIVE STREET ADDRESS) Box Secor's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Handyman	12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. USUAL RESIDENCE (IF ABSENCING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE md	13b. COUNTY A.A.	13c. CITY OR TOWN GlenBurnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7998 Crain Highway 21061	
14. FATHER'S NAME FIRST MIDDLE LAST William Evans		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Unknown			
16a. WAS DECEASED EVER (YES, NO OR UNKNOWN) No	16b. U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) 11/11/11	16c. SOCIAL SECURITY NO. 219-54-3160	17. INFORMANT (Nephew) ADDRESS Linton B. Pumphrey Arnold, Md 21012		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 1889 DUE TO, OR AS A CONSEQUENCE OF (b) renal outlet obstruction DUE TO, OR AS A CONSEQUENCE OF (c) bladder carcinoma stage D					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/18 1984 to 3/22 1984, that (I) (we) lost saw the deceased alive on 3/22 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated either (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ray Brodie, Jr MD		DEGREE MD		22c. DATE SIGNED 3/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAY Brodie, Jr MD		22e. ADDRESS 844 N. Carey St 21217			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 26, 1984	23c. NAME OF CEMETERY OR CREMATORY GlenHaven Mem. Prk		23d. LOCATION CITY OR TOWN COUNTY STATE GlenBurnie A.A. Md
24. FUNERAL DIRECTOR Singleton Funeral Home GlenBurnie, Md		25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE P. Davidson-Randall	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Handwritten scribbles at the top right corner.



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1874 JAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

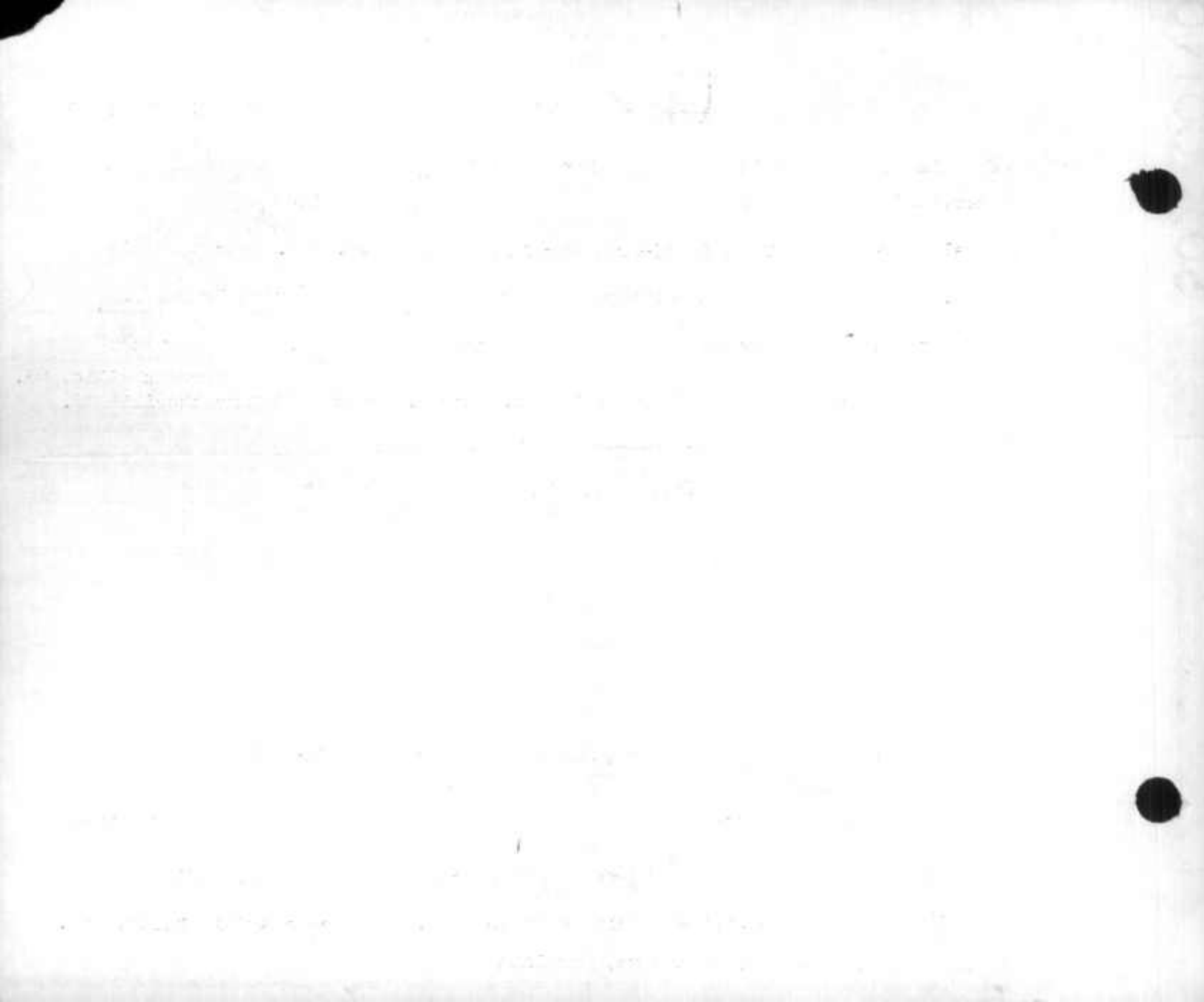
06840

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH WHITNEY EVANS			2a. DATE OF DEATH MONTH DAY YEAR 3 31 84			2b. HOUR 7:30P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 22, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) B.G. & E. Auto Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 5642 Purdue Avenue 21239		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. Evans				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary T. Coulter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW IT 213-20-3901		17. INFORMANT ADDRESS Jarrettsville, Md. Mr. Gary M. Evans 1436 Jarrettsville Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 1459 DUE TO, OR AS A CONSEQUENCE OF (b) <u>STAGE IV SQUAMOUS CELL CARCINOMA</u> OF THE ORAL CAVITY DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>MARCH 9</u> , 19 <u>84</u> , to <u>MARCH 31</u> , 19 <u>84</u> , that <u>X</u> (we) lost saw the deceased alive on <u>MARCH 31</u> , 19 <u>84</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.									
22b. SIGNATURE <u>V. Shusterov</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VLADIMIR L. SHUSTEROV					22e. ADDRESS VAMC, Baltimore, Maryland 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 4, 1984		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto, Md.		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE <u>Davidson Handell</u>		

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06841

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Howard S. Everett, Sr.</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>26</b> YEAR <b>84</b> HOUR <b>6:05a</b>		
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>17</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION <b>Plant Operat. Superintendant</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Md.</b> 12b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Georgia</b> MIDDLE <b>A.</b> LAST <b>Colefield</b>		13e. STREET ADDRESS <b>Balto., Md.</b> <b>1516 Clairidge Rd. #21207</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 194-14-2555</b>		17. INFORMANT <b>Mrs. Janet Everett</b> ADDRESS <b>1516 Clairidge Rd. Balto., Md. #21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUNG CANCER (CARCINOMA OF LUNG)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-22</b> , 19 <b>81</b> , to <b>3-26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>W. Anthony mn</b>		DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-26-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Anthony mn</b>		22e. ADDRESS <b>827 LINDEN AVE, BALTO MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 30, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem</b>	
23d. LOCATION CITY OR TOWN <b>Crownsville,</b>		COUNTY <b>Md.</b>		STATE	
24. FUNERAL DIRECTOR <b>G. Thomas Schwab</b>		5151 Balto. Nat'l. Pike <b>#21229</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 4 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>John K. ...</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





RECEIVED  
JAN 12 1967

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										0 6 3 4 2									
1. DECEASED NAME (TYPE OR PRINT) <b>SOPHIA J FADROWSKI</b>										2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>3-26-84</b>									
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3-14 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2. DATE PRONOUNCED DEAD <b>3-26-84</b>		24. HOUR <b>1:35</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3544 Chesterfield Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>							
13a. STATE <b>Maryland</b>				13b. COUNTY <b>-----</b>				13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13e. STREET ADDRESS <b>3544 Chesterfield Ave. 21213</b>				14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Stephen Kitowski</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Apolonia Unknown</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-66-9955</b>				17. INFORMANT <b>Richard P. Burke Sr.</b>				ADDRESS <b>3544 Chesterfield Ave. Baltimore, Md. 21213</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER								DATE SIGNED <b>3-26-84</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/29/84</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home</b>				ADDRESS <b>3331 Brehms Lane Balto., Md. 21213</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b>				25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>							

INVESTIGATION REPORT  
NO. 100-100000-100000

100-100000-100000

100-100000-100000

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100-100000-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E FAHRENBACH					2a. DATE OF DEATH MONTH DAY YEAR 3 19 84				2b. HOUR 4:47 A.M.
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 14 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE	
13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN H. FAHRENBACH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA KAUFFMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN		17. INFORMANT DR. MARVIN FAHRENBACH-BROTHER-TOMPKINS COVE,		ADDRESS NEW YORK...			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>84</u> , to <u>3/19</u> 19 <u>84</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/19</u> 19 <u>84</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)(we)(did)</u> did not view the body after death.									
22b. SIGNATURE <u>William J. Hicken M.D.</u>		DEGREE		22c. ADDRESS <u>St Agnes Hospital</u>				22d. DATE SIGNED <u>3/19/84</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. J. HICKEN, M.D.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 22/1984		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN UNITED METH. CH.		23d. LOCATION CITY OR TOWN COUNTY STATE WERNERSVILLE, PENNA.			
24. FUNERAL DIRECTOR HYSONG CO., INC. - 1300-N ST., N.W. WASH., DC				25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>LAURETTE P. FARDWELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>03 08 84</b>				2b. HOUR <b>2<sup>10</sup> A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 16, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Balto. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Smith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Price</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214 74 2562</b>		17. INFORMANT ADDRESS <b>Virginia F. Otto</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac-Respiratory Arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Anterior MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Third Degree Heart Block, Pneumonia</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>84</b> , to <b>3/8</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Robert A. Miller</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT A. MILLER M.D.</b>				22e. ADDRESS <b>201 EAST UNIVERSITY PARKWAY</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>March 12, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home, P.A.</b>				ADDRESS <b>Balto. Md. 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Juha Davidson</b>	

100-100000

RECEIVED

LAURETTE

BALTIMORE CITY

THE UNION NATIONAL HOSPITAL

BALTIMORE

THE UNION NATIONAL HOSPITAL

BALTIMORE, MARYLAND

CHIEF OF CLINICAL MEDICINE

DR. J. H. HARRIS

100-100000

RECEIVED

LAURETTE

100-100000

JOHN HAST UNIVERSITY PARKWAY

ROBERT A. HENDER M.D.

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner will be notified about it.

FOR Item #16a Film #G589  
1- STATE REGISTRAR 3/15/84 jp

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WAYNE MINTON FARRINGTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 4 84</b>			2b. HOUR <b>8:07p</b> M					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 6 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC 3900 LOCH RAVEN BLVD BALTO, MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Edgewood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>300 Palmetto Drive 21040</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Freddie Silvester Farrington</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emeline -- Taylor</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>				16b. SOCIAL SECURITY NO. <b>244141093</b>	
17. INFORMANT <b>Mrs. Grace E. Farrington</b>			ADDRESS <b>Edgewood, Md. 21040</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary arrest</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post obstructive pneumonia</b> (c) <b>metastatic lung adenocarcinoma</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>1 month</b> <b>greater than 1 month</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>month</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 10</b> , 19 <b>84</b> , to <b>MARCH 4</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 4</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <b>Michael J. Buchanan</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/5/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL J. BUCHANAN</b>			22e. ADDRESS <b>3900 LOCH RAVEN BLVD 21218</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>Mar. 5, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reins-Sturdivant F.H.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>N. Wilkesboro Wilkes N.C.</b>				
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>			ADDRESS <b>Abingdon, Md. 21009</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP

✓ 3/12/24

MD

Michael J. Brennan  
LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 03 14 84			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Oliver FARRIS				2b. HOUR 3 <sup>00</sup> A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 01 20 18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired Rigger/Md. Drydock		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md. 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 601 Lorca Ave. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Oliver FARRIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Hughes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 27805427		17. INFORMANT ADDRESS Same as #13 H. Bobeck Margaret Farris			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 03-08 19 84 to 03-14 19 84, that (I) (we) lost saw the deceased alive on 3-14-19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry Bobeck DEGREE				22c. DATE SIGNED 3-14-84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Bobeck	
22e. ADDRESS South Baltimore General Hosp				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/17/1984		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A. A. Co., Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto. Md., 21225 237 E. Patapsco Ave.,				25a. DATE REC'D. BY REGISTRAR MAR 15 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

Compton

212  
Av.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06847

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MILTON STEPHEN FEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 08 84</b>		2b. HOUR <b>2:30 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 27 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL - E.R.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OPERATING ENG.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ROAD CONSTRUCTION</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>ARBUTUS</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MILTON FEE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BIRDIE V. UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW II</b>		16b. SOCIAL SECURITY NO. <b>217-07-3121</b>	17. INFORMANT ADDRESS <b>SAM J. PRETE 5131 WESTLAND BLVD., 21227</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> (c) <b>Diabetes mellitus</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, IF NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Semily</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>82</b> , to <b>Jan</b> , 19 <b>84</b> ; that (I) (we) lost saw the deceased alive on <b>Jan</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Barahona</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/9/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEONEL BARAHONA, M.D.</b>		22e. ADDRESS <b>1101 MAIDEN CHOICE LANE, 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>03-12-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN MEM. GAR.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSTVILLE HOWARD MD.</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>12 12 1984</b> 25b. REGISTRAR'S SIGNATURE <i>John S. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06848

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes", the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph Anthony FELICE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 31 84</i>			2b. HOUR <i>5:20 PM</i>		
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 26 20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>?</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>City Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>?</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>?</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael Felice</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Domenica DeFlorio</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II</i>		16c. INFORMANT <i>Mr. Monroe</i>		ADDRESS <i>3rd floor Balto. City Social Services 1510 Guilford Ave</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic colonic adenocarcinoma</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>jaundice 20 liver metastasis</i>								
19a. DATE OF OPERATION <i>3/31</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>liver metastasis</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>3/31</i> 19 <i>84</i> to <i>3/31</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>3/31</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Patricia J. Coon</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/31/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PATRICIA J. COON</i>				22e. ADDRESS <i>5200 Eastview Ave, Balto, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>04/04/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Jesus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Baltimore Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Walter Brooks Bradley, Inc. Dundalk, MD 21222</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 6 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		



LIBER

DOWN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>Alexander</u> <u>Felsky</u>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 28 1984	
3. SEX <u>Male</u> 4. RACE <u>White</u> 5. DATE OF BIRTH <u>May 26, 1894</u> 6. AGE (IN YEARS) <u>89</u> YRS. 7. DATE OF BIRTH MONTH DAY YEAR 8. IF UNDER 1 YR. MONTHS DAYS 9. IF UNDER 24 HRS. HOURS MIN.										2b. HOUR <u>1:05</u> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Wisconsin</u> 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <u>4 8 1984</u> 2d. HOUR <u>1:05</u> M	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City,</u> MD.											
10. CITY OR TOWN OF DEATH <u>Baltimore</u> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1536 Clarkson Street Balto. Md.</u> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Machinist, Crown</u> 12b. KIND OF BUSINESS OR INDUSTRY <u>Cork &amp; Seal</u>											
13a. STATE <u>Maryland</u> 13b. COUNTY <u>-----</u> 13c. CITY OR TOWN <u>Baltimore</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>1536 Clarkson St. Balto. Md.</u>											
14. FATHER'S NAME FIRST <u>Unknown</u> MIDDLE <u>-----</u> LAST <u>-----</u> 15. MOTHER'S MAIDEN NAME FIRST <u>Unknown</u> MIDDLE <u>-----</u> LAST <u>-----</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>1921-1924</u> 16b. SOCIAL SECURITY NO. <u>215-10-8234</u> 17. INFORMANT <u>Eva B. Standiford, 2419 Stoney Brook Rd. 21047</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <u>4292</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>-----</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-----</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION <u>-----</u> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>-----</u> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>-----</u> 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>-----</u> P.M. <u>19</u> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>-----</u>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>-----</u> 21f. LOCATION CITY OR TOWN <u>-----</u> COUNTY <u>-----</u> STATE <u>-----</u>											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> (Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TIME (SPECIFY) <u>-----</u>											
ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> M.D. Assistant MEDICAL EXAMINER DATE SIGNED <u>4/9/84</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>Dennis F. Smyth, M.D.</u> ADDRESS <u>111 Penn St. Balto., MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> 23b. DATE <u>April 11, 1984</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u> 23d. LOCATION CITY OR TOWN <u>Elkridge, Howard Co. Maryland</u> COUNTY <u>Howard</u> STATE <u>Maryland</u>											
24. FUNERAL DIRECTOR NAME <u>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</u> ADDRESS <u>21230</u> 25a. DATE REC'D. BY REGISTRAR <u>APR 12 1984</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>											

MEDICAL CERTIFICATION

171



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06850

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BETTY ANN FELTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 11, 1984</b>		2b. HOUR 12:00 <sup>AM</sup>
3. SEX <b>F</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 1 34</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE AIDE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>
13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Anderson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lois</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-36-3432</b>	17. INFORMANT ADDRESS <b>Michael Felton 438 OAKLAND ST</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) <b>anoxic encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>3 wks.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>chronic renal failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>84</b> , to <b>3/11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>DM. Herrington</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/11/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Herrington</b>		22e. ADDRESS <b>Dept. of Med. J.H.H. Baltimore Md. 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-15-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>
24. FUNERAL DIRECTOR NAME <b>M.P. Hayes</b>		ADDRESS <b>Funeral Home 638 N 9th St</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Felia Davidson-Pandora</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 of this certificate should be completed and completely filled in by the attending physician. The law requires that the death certificate be executed within 24 hours after death. Part 1 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>STEPHEN B. Ferguson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-4-84</b>		2b. HOUR <b>6:30 A.M.</b>
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 7 55</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>28</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard R. Ferguson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie McMorris</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-66-3107</b>	17. INFORMANT ADDRESS <b>Lane</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardioresp. arrest</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARDS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pneumonia, Alcohol withdrawal syndrome</b> DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>3/3</b> 19 <b>84</b> , to <b>3/4</b> 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>3/4</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. Hawke</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-4-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Hawke</b>		22e. ADDRESS <b>Baltimore City Hospitals 64940 Eastern Ave. Balto, 21224</b>			
23a. BURIAL, CREMATION, REMOVAL (1) <b>BURIAL</b>		23b. DATE <b>3/9/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>			25a. DATE REC'D. BY REGISTRAR <b>06 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lila Davidson-Randall</b>

Date	Description	Amount	Balance	Total	Remarks
1/1/20	Opening Balance	100.00	100.00	100.00	
1/2/20	Cash Sale	50.00	150.00	150.00	
1/3/20	Cash Sale	25.00	175.00	175.00	
1/4/20	Cash Sale	75.00	250.00	250.00	
1/5/20	Cash Sale	125.00	375.00	375.00	
1/6/20	Cash Sale	175.00	550.00	550.00	
1/7/20	Cash Sale	225.00	775.00	775.00	
1/8/20	Cash Sale	275.00	1050.00	1050.00	
1/9/20	Cash Sale	325.00	1375.00	1375.00	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06852

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bernice Fialkewicz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 13 84</b>			2b. HOUR <b>9<sup>25</sup> AM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 3 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>self-emp</b>		13a. STREET ADDRESS <b>4517 Shamrock Avenue 21213</b>					
13b. COUNTY <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4517 Shamrock Avenue 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Gostomski</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Landowski</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Silver Walter Fialkewicz 2908 Randolph Rd. Springs</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John P. Joyce MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/13/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John P. Joyce MD</b>				22e. ADDRESS <b>Balt. City Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Of Mary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>				ADDRESS <b>1005 Dundalk Avenue</b>		MAR 21 1984 John Dabrowski	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

1005 Landa Avenue

2015

[ 117 ]

SECRETED REPORT OF BARRY

SECRET

unlabeled

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LAURA Madline FIALKOWSKI</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 26 1984</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 31 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 28 1984</b>		2d. HOUR <b>5:55 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2007 Eastern Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FUNERAL DIRECTRESS</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FUNERAL</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO. CITY</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2007 EASTERN AVE. BALTO. MD.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN WOJCICKI</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA DOWNAR 21231</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-52-1815</b>		17. INFORMANT ADDRESS <b>WM. FIALKOWSKI-1769 STOKESLEY RD. BALTO. MD. 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4029 IMMEDIATE CAUSE (a) Hypertensive &amp; arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED <b>3-29-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>						ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3 /31/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. COUNTY MD.</b>			
24. FUNERAL DIRECTOR NAME <b>W. FIALKOWSKI</b>						ADDRESS <b>2 007 EASTERN AVE. MD. 21231</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

RECEIVED BY THE DIRECTOR  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

on June 10, 1964

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-155555)

SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]  
[Illegible]

DATE: 6/10/64

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-155555)

DATE: 6/10/64

NO

100-155555-100

100-155555-100

100-155555-100

100-155555-100

100-155555-100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06854

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLOTTE MARIE FICK</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>84</b>		2b. HOUR <b>1:30 AM</b>
3. SEX <b>Female</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>12</b> YEAR <b>05</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP OF BALTO</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>	13b. COUNTY <b>Arbutus</b>	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4116 College Avenue 21227</b>	
14. FATHER'S NAME FIRST <b>Lewis Charles</b> MIDDLE <b>Richter</b> LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Schwartz</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-03-6728 A</b>		17. INFORMANT ADDRESS <b>Augsburg Lutheran Home 21207</b> <b>6811 Campfield Road Baltimore, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> <b>5850</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic renal failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1984</b> to <b>April 19, 1984</b> , that (I) (we) last saw the deceased alive on <b>April 19, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John P. Young</b>		DEGREE <b>Physician</b>		22c. DATE SIGNED <b>3/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN P. YOUNG</b>		22e. ADDRESS <b>SINAI HOSP OF BALTO</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/10/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City, Maryland</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

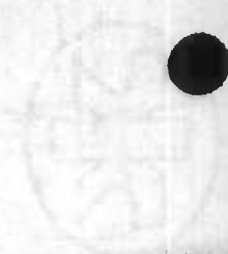
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



For the Bureau of Investigation  
Washington, D. C.

10/10/54



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George W. Fields</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 23 19 84</b>				2b. HOUR <b>4:12</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 13 17 66</b> YRS.	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 23 19 84</b>		7d. HOUR <b>4:12</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1803 W. Lexington St.</b> 21223	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Fields</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Burrell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Edna Johnson 1213 N. Dukeland St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>3/25/84</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>11 Penn St. Balto.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D BY REGISTRAR <b>MAR 27 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>	

BP



DAVID WHITE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06856

1- FOR  
STATE  
REGISTRAR

REG. NO.

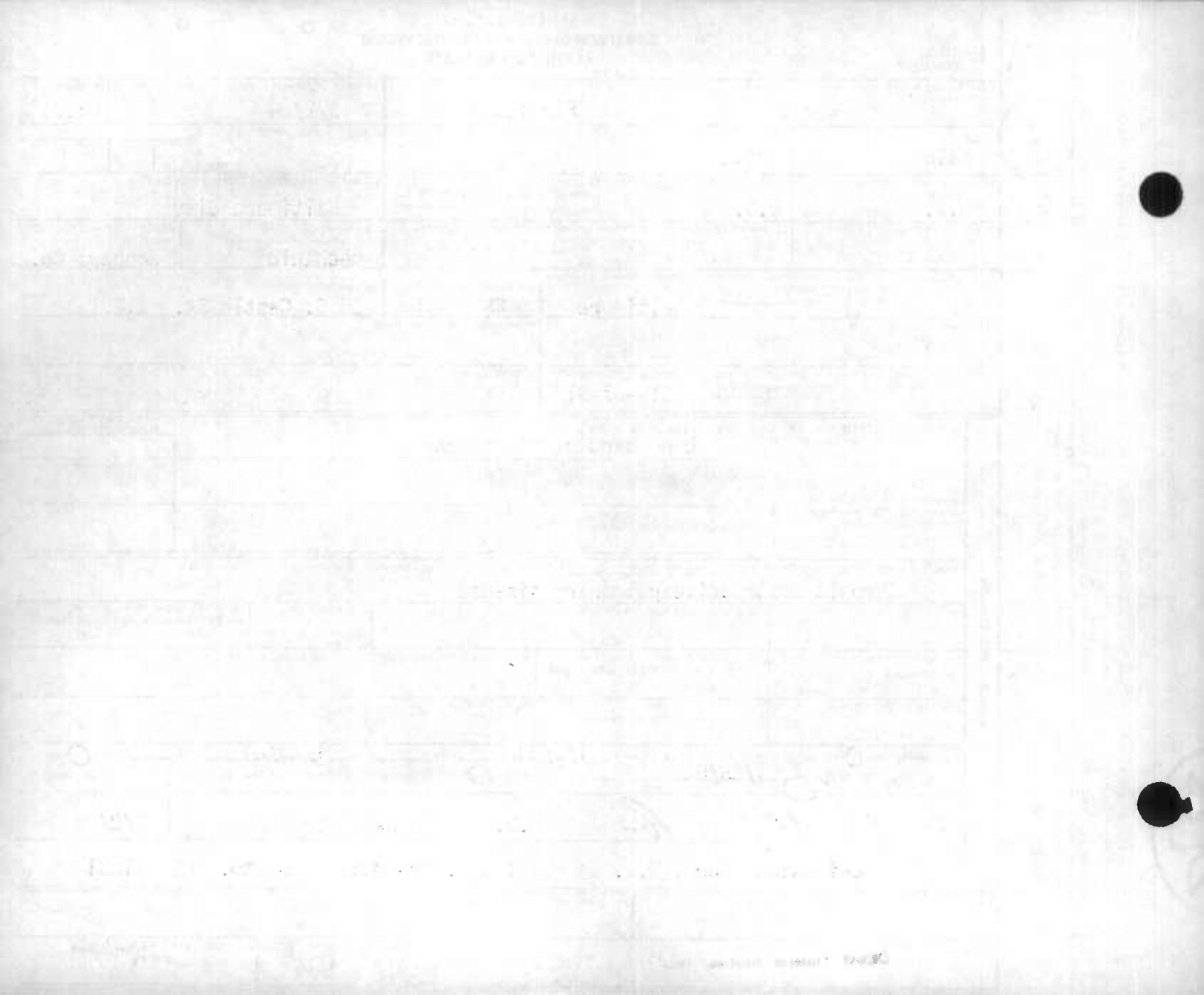
1. DECEASED NAME (TYPE OR PRINT) George D. Fingleton			2a. DATE OF DEATH MONTH DAY YEAR 3/2/84			2b. HOUR 8:07a M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9/28/05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S. Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 28 S. Castle Street 21231				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanic	
						12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Fingleton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-07-9180		17. INFORMANT ADDRESS 21231 Catherine Fingleton 28 S. Castle St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung cancer, right lung 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive pulmonary disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/3/84, 19_____, to 1/28/84, 19_____, that (I) (we) lost saw the deceased alive on 1/28/84, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE X Ch-Shiang Chen				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chi-Shiang Chen, M.D.				22e. ADDRESS 100 N. Broadway Balto., MD 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 5, 84		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md	
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc.				ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR MAR 6 1984	
				25b. REGISTRAR'S SIGNATURE Jana Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST	MIDDLE	LAST		MONTH	DAY	YEAR			
Cornelius Finney				March 20, 1984				11:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		MONTH DAY YEAR		70 years		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Va.		USA				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE			
STATE Maryland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		911 N. Parrish Street 21217			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Richard Finney				FIRST MIDDLE LAST Mary Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		16c. ADDRESS			
Unkn. Yes				212-01-0486		1223 W. Lombard St. Balto., MD. 21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:								48 Hours	
IMMEDIATE CAUSE (a) <u>respiratory Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bilateral Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Dehydration; Anemia.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>March 19, 1984</u> to <u>March 20, 1984</u> , that (X) (we) lost the deceased alive on <u>March 20, 1984</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			
<u>M. Shaukat</u>			M.D.			3/21/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Maimoona Shaukat, M.D.			c/o Maryland General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			4/9/84		Cem.		Owings Mills, Md.		
Removal			3/23/84		Garrison Forest VA				
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
March Funeral Home, North Ave. Anatomy Board Balto., Md.			MAR 28 1984			<u>Shirley Gordon</u>			

BP 20



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN L. FISHER</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-17-84</b>		2b. HOUR <b>10:30</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 14 1927</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>56 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3-17-84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7 S. Wolfe St. St. Michael Church</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Custodian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
13a. STATE <b>Md.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>700 S. Wolfe St. (21231)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. Fisher</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice L. Schnieder</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. <b>216-20-2160</b>				17. INFORMANT ADDRESS <b>Francis G. Fisher 5922 Theodore Ave.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lungs</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. <b>Assistant</b>				DATE SIGNED <b>3-18-84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>3/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Fisher</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lawrence W. Fitzhugh			2a. DATE OF DEATH MONTH DAY YEAR 3/1/84		2b. HOUR 1:30 A M	
3. SEX male	4. RACE col	5. DATE OF BIRTH MONTH DAY YEAR 12-15-1915	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Fitzhugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Fitzhugh				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW II 219-01-9187		17. INFORMANT ADDRESS Mrs. Grace Fitzhugh 1952 Ridgehill Ave 21217		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction, probable 4100 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease 4 years DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Congestive Heart Failure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/2 1983 to 2/29 1984, that (I) (we) lost saw the deceased alive on 12/16 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Rifat Abousy MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rifat Abousy				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 3-6-84		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2222 W. North Ave.		25. DATE REC'D. BY REGISTRAR MAR 2 1984
25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

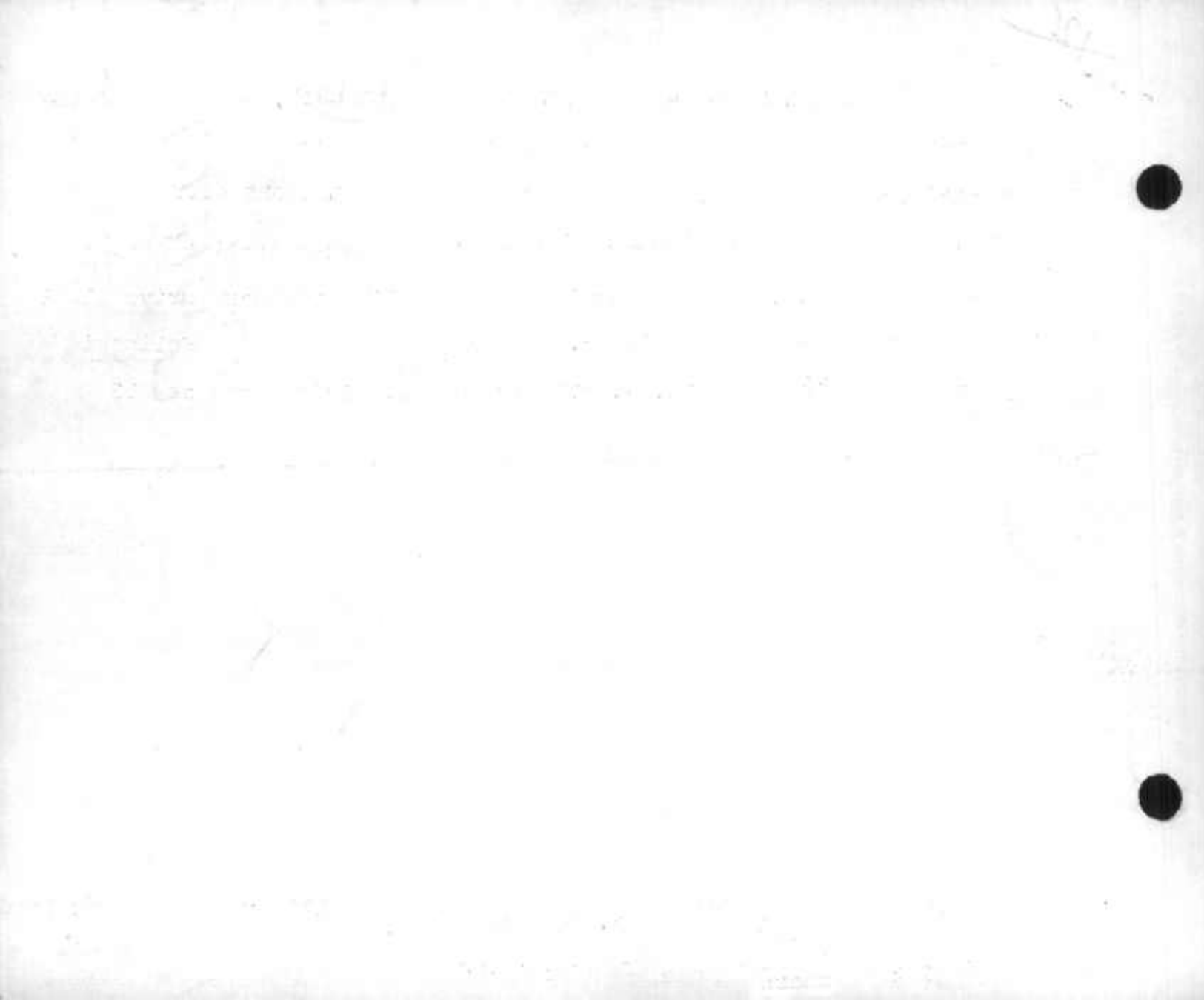
BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CHARLES Preston FLEIG		2a. DATE OF DEATH MONTH DAY YEAR MARCH 17, 1984		2b. HOUR 9:10A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 1, 1946		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) System Analyst		12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Preston Fleig Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Helinski		16. SOCIAL SECURITY NO. 212.42.9971		17. INFORMANT (Wife) ADDRESS Margaret J. Fleig Same as #13	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		18b. SOCIAL SECURITY NO. (1946-1954) 196		18c. DATE OF DEATH 2028		18d. DATE OF DEATH 6/20/83 9mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Syncope</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6/20/83 9mo.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>84</u> , to <u>3/17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Bram Riekman</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bram Riekman MD		22e. ADDRESS Baltimore C.H. Hospital					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE March 20 1984		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION Baltimore COUNTY Maryland	
24. FUNERAL DIRECTOR NAME Singleton		24b. ADDRESS Funeral Home Glen Burnie, Md		25a. DATE REC'D. BY REGISTRAR MAR 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06861

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST HERMAN MIDDLE FLEISHMAN LAST FLEISHMAN		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		70 YRS		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY FOOD DISTRIBUTOR	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO. HGLDS.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4427 FENOR ROAD, 21227	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK FLEISHMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE MARTIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 216-05-5484		17. INFORMANT RUTH V. FLEISHMAN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5198 IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Airway obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Squamous Cell Carcinoma of larynx - metastatic</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 5 min 3 mo		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 1/3/84 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell ca of tonsil 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Harry S. Strothers Jr		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRY S. STROTHERS JR MD		22e. ADDRESS 611 S. Charles St. Balt md 21230		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					
23b. DATE 03-31-84		23c. NAME OF CEMETERY OR CREMATORY CREST LAWN MEM. GARD.		23d. LOCATION CITY OR TOWN COUNTY STATE MARRIOTTVILLE HOWARD MD.		24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229			
25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OF DEATH) <b>NANCY P FLETCHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/17/84</b>		2b. HOUR <b>10:00 M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 09 09</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b>		10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>2819 WINCHESTER ST.</b>		
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO CITY</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fenton Peele</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Peele</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
16b. SOCIAL SECURITY NO. <b>217094185</b>		17. INFORMANT <b>Mamie Wilkins</b>		ADDRESS <b>1011 Railroad Ave. Suffolk, Va. 23434</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4360 Double pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)			
DUE TO, OR AS A CONSEQUENCE OF (b)		<b>CVA</b>	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-05-84</b> , 19 <b>84</b> , to <b>3/17/84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/17/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Sissay Awoka</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OF PHYSICIAN) <b>Sissay Awoka</b>		22e. ADDRESS <b>Lutheran Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-24-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carver Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suffolk VA.</b>					

24. FUNERAL DIRECTOR NAME <b>Chas. A. Rice FSPA 1300 Eutaw Pl.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be bound within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH ANDREW FOARD			2a. DATE OF DEATH MONTH DAY YEAR MARCH 22, 1984			2b. HOUR 9:38a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 26, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Retired		12b. KIND OF BUSINESS OR INDUSTRY Service	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Foard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Cromwell			13e. STREET ADDRESS / ZIP CODE 7814 Shepherd Ave 21234			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs Helen R Foard Same As 13E				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest  
5739  
DUE TO, OR AS A CONSEQUENCE OF  
(b) End-stage Liver Disease  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

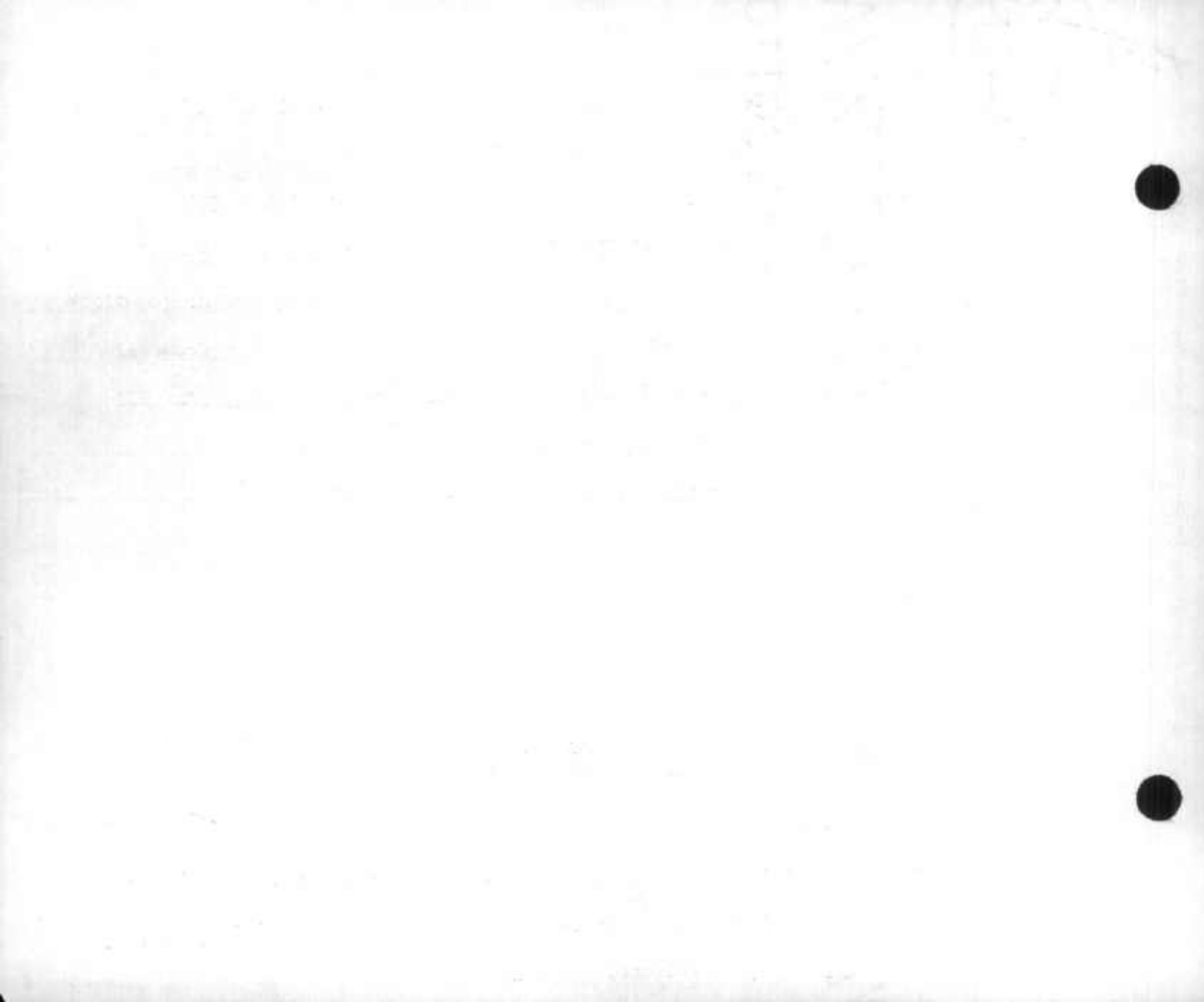
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1X) (this hospital) attended the deceased from <u>March 6,</u> 19 <u>84</u> , to <u>March 22,</u> 19 <u>84</u> , that (X) (we) last saw the deceased alive on <u>March 22,</u> 19 <u>84</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do not) view the body after death.							
22b. SIGNATURE C Bradley MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Bradley M.D.				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Md	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 23 1984			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 6 8 6 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE D. FOGLE</b>			2a. DATE OF DEATH MONTH <b>1984</b> <b>MARCH 3 18 84</b>		2b. HOUR <b>9<sup>0</sup> A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH <b>AUG 8 1943</b> MONTH DAY YEAR <b>8 8 43</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City MD</b>	
10. CITY OR TOWN OF DEATH <b>Balto City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of MD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COOK</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD SERV.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1718 S. Deland St 3229</b>	
14. FATHER'S NAME FIRST <b>Arthur</b> MIDDLE <b>L</b> LAST <b>Fogle</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Alberta</b> MIDDLE <b>—</b> LAST <b>Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-44-3685</b>		17. INFORMANT ADDRESS <b>ALBERTA FOGLE/832 ALLENDALE ST 21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoxia</b> <b>5140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <b>Hepatic Failure</b>					
19a. DATE OF OPERATION <b>NIA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NIA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>84</b> , to <b>3/18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>V. Burgis</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/18/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. Burgis</b>		22e. ADDRESS <b>22 S. Greene St Balto MD 21202</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03/22/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR <b>MARSHALL W. JONES, JR.</b> NAME ADDRESS <b>4101 EDMONDSON AVE./BALTO., Md. 21229</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone or in person.

BP

FORM 10

55-2 (Name of Baltimore MD 515)

1. Bridge

MD

X 318108

518 515 84 84 84

NIA

X

Hepatic Failure

Hypoxia

515-502

Fog

Albino

SMITH

X

Ballo

MD

City of MD

Baltimore

X

Male

515-502

Fog

Class D

515-502

40

3 18 81 P A

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked by the funeral director, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN FOLAND				2a. DATE OF DEATH MONTH DAY YEAR 3 14 84			
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 5 4 88		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALTO		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNK.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nette Barron			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-20-9250		17. INFORMANT ADDRESS Maurice Foland, 3409 Bateman Ave 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5789 HYPOTENSIVE SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) UGI bleed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>X-1984</u> 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JOHN P. YOUNG		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P. YOUNG		22e. ADDRESS SINAI HOSP OF BALTO					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/16/84		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Funeral Home, 263 S. Conkling				25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) baba boydson AVE. 21201 Forbes					2a. DATE OF DEATH MONTH DAY YEAR 3 31 84			2b. HOUR P 9:50 M	
3. SEX Male		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 3 31 84		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3 1 50		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland					13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Marian Forbes					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Forbes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac + respiratory arrest</u> <u>7650</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe immaturity.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7 PM 3-31, 1984</u> , to <u>9:50 PM 3-31, 1984</u> , that (I) (we) last saw the deceased alive on <u>9:50 PM 3-31, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Salem Al Naber			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALEM AL-NABER			22e. ADDRESS Mercy hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 3/4/ 4/5/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS Balto., Md.			25. DATE RECEIVED BY FUNERAL HOME APR 1 1984			

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APR 1 1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

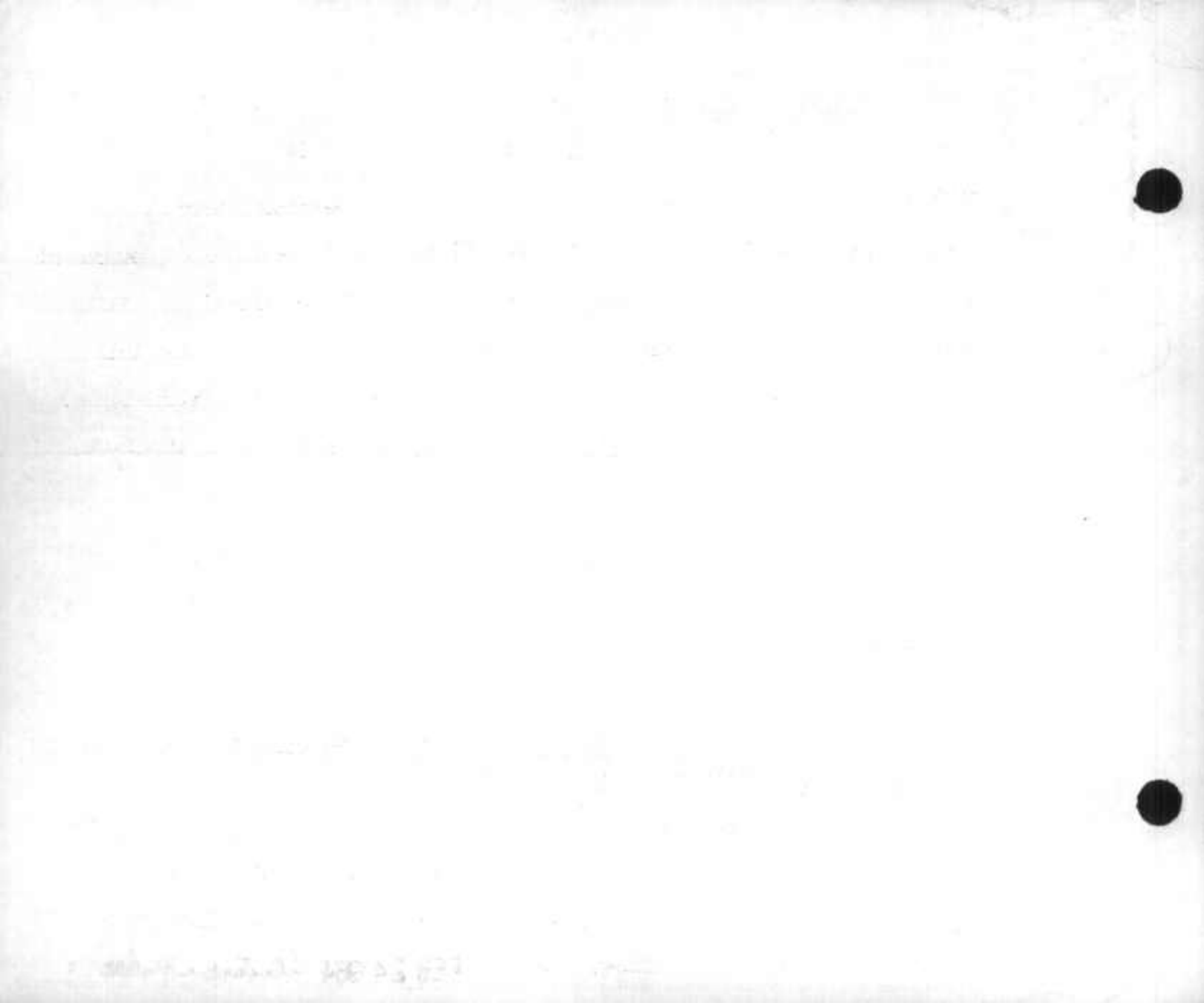
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PHILIP HENSON FORD			2a. DATE OF DEATH MONTH DAY YEAR 2 18 84			2b. HOUR 1:05P M		
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 12-12-23 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2742 The Alameda 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Philip Henson Ford			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Singfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) W.W. II 219-16-1717		17. INFORMANT ADDRESS Martha Reed 2742 The Alameda Balt., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic - Pulmonary Disease</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>② side pleural mesothelioma</u> (c) <u>Due to, or as a consequence of</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2/19/84								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 31</u> 19 <u>84</u> , to <u>February 18</u> 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>February 18</u> 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE <u>Clarence Smith</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 2/20/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clarence Smith			22e. ADDRESS VAMC, Baltimore, Maryland 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-24-84		23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince George MD	
24. FUNERAL DIRECTOR NAME Thornton's Funeral Home Pomonkey, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE FEB 24 1984 <u>John L. Jordan</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 6 8 6 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles D. Foreman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 4 84</i>		2b. HOUR <i>3:20 PM</i>	
3. SEX <i>M</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 4 09</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		7. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
12. CITY OR TOWN OF DEATH <i>Baltimore</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MASON LLOYD EASTERN AVE.</i>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SECURITY OFFICER APT Security Sys</i>		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>David FOREMAN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Louisa Adams</i>		16. STREET ADDRESS <i>3315 Fair Ave Baltimore.</i>		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		18. SOCIAL SECURITY NO. <i>215 22 4319</i>		19. INFORMANT ADDRESS <i>H. Lee Allers 28 Allegheny Ave. Towson, Md.</i>		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio vascular arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>per decubital ulcer</i> Approximate interval between onset and death: <i>secs.</i> <i>days</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Dementia</i>						
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3/4 84</i>		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21h. LOCATION STREET CITY OR TOWN COUNTY STATE <i>BCH 15200 Eastern Ave</i>		21i. DATE SIGNED		
22. I certify that (I) (this hospital) attended the deceased from <i>3/4 84</i> to <i>3/4 84</i> , that (I) (we) saw the deceased prior on <i>3/4 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.)						
23. SIGNATURE <i>Patricia Jay Conn</i>		24. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Patricia Jay Conn</i>		25. ADDRESS <i>BCH 15200 Eastern Ave</i>		
26. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		27. DATE <i>Mar. 12, 1984</i>		28. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Jesus</i>		
29. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</i>		30. DATE REC'D. BY REGISTRAR <i>MAR 13 1984</i>		31. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low required for the death certificate is returned in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or a physician who is not a resident of the State, it should be detached for use as the burial/transit permit. Then please return it to the funeral home. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. (If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified for an autopsy.)

FOR  
1 - STATE  
REGISTRAR

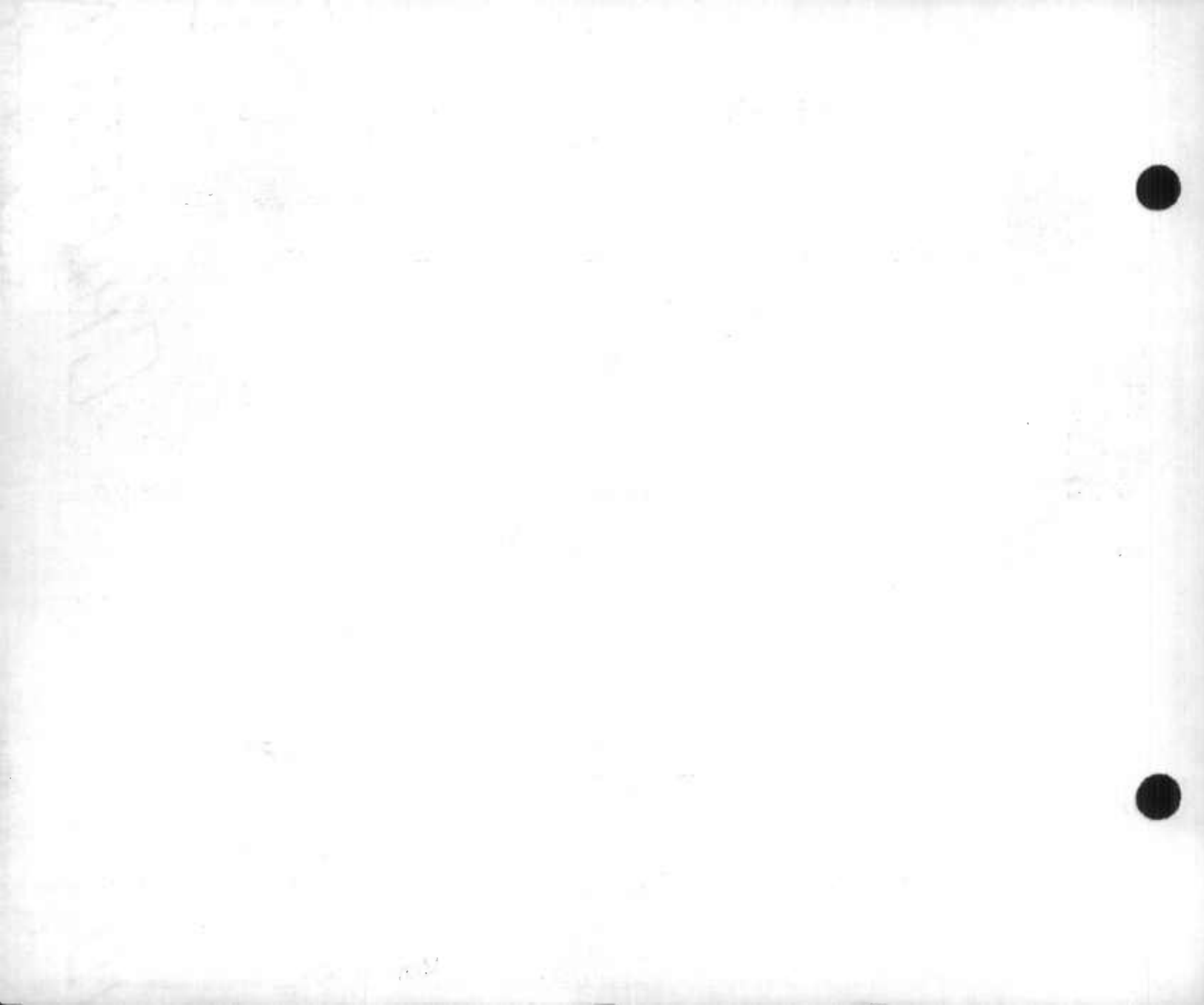
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) (Jason) (Lawrence) (FOSTER) BABY BOY			2a. DATE OF DEATH MONTH DAY YEAR 03 25 84			2b. HOUR 5:12PM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 23 1984		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 2		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12726 New Windsro Rd. 21791	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Ray Foster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorretta Faye (Coyle, Hill)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Lawrence Foster, Union Bridge, Md. 21791						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7479 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) hypoxemia DUE TO, OR AS A CONSEQUENCE OF (c) persistent fetal circulation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 2 days 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from March 25, 19 84, to March 25, 19 84, that (I) (we) lost saw the deceased alive on March 25, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Cynthia F. Bearer				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/25/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CYNTHIA F. BEARER				22e. ADDRESS Johns Hopkins Hosp. Balt., Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/28/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.				
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer, Frederick, Md. 21701				25a. DATE REC'D. BY REGISTRAR MAR 30 1984		25b. REGISTRAR'S SIGNATURE				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Catherine</i> MIDDLE <i>Fowler</i> LAST <i>Fowler</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>3 16 84</i>		2b. HOUR <i>1 30 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 12 08</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY _____		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST <i>George</i> MIDDLE _____ LAST <i>Wachter</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Margaret</i> MIDDLE _____ LAST <i>Kalb</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-10-8560</i>		17. INFORMANT <i>Kenneth E. Fowler</i>	
				ADDRESS <i>613 S. Rappolla St 21224</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*4275*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/12</i> , 19 <i>84</i> , to <i>3/16</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>3/16</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John Joyce MD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/16/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Joyce MD</i>		22e. ADDRESS <i>Balt. City Hosp. Balt MD</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-19-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dundalk Balto. Co. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>				ADDRESS <i>6224 Eastern Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 19 1984</i>	
				REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-3, RETURN, PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mildred		MIDDLE Frank		LAST		3 23 1984	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR 4:58P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. 404 1190 W. NORTHERN PKWY. #21210	
14. FATHER'S NAME FIRST HARRY		MIDDLE		LAST FLINKMAN		15. MOTHER'S MAIDEN NAME FIRST ANNA		MIDDLE BEHRMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-01-5892		17. INFORMANT MRS. BEATRICE MOSTWILL 1190 W. NORTHERN PKWY., APT. 404 #21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOURS MONTH DAY YEAR 4:26 P.M. 3 23 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET Northern Pkwy & Falls Rd, Baltimore City, Md.					
22a. I certify that I took charge of the remains described above, held an depth resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 3/24/84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St. Balto, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-25-84		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION BALTIMORE		COUNTY MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Bridell			

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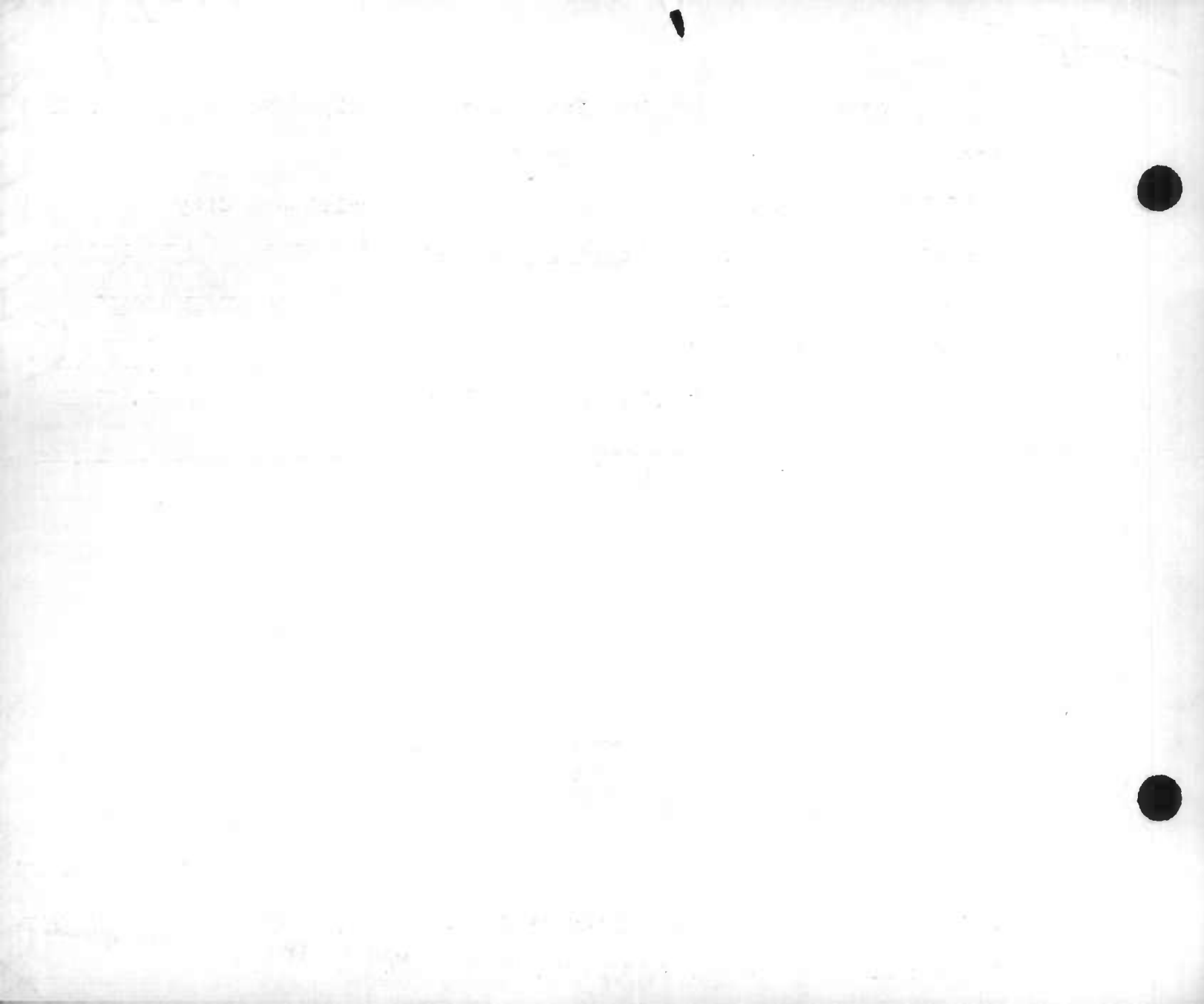
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1E states any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>John Earnest Frankhouse</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>03/05/84</b>			
3. SEX <b>MALE</b>				4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 17, 1938</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2b. HOUR <b>1:00P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LEWISTOWN, PENN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>INDEPENDENT</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER FACILITY, GIVE STREET ADDRESS) <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY EARNEST FRANKHOUSE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN KAISER</b>		13e. STREET ADDRESS / ZIP CODE <b>839 S. BOND STREET 21231</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213.34.3272</b>		17. INFORMANT ADDRESS <b>1144 QUANTRAL WAY BALTO., MD. 21205</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>spinal cord compression</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>small cell CA of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with metastases</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>84</b> , to <b>3/5</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Stephen Chedd</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/5/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen Chedd</b>		22e. ADDRESS <b>N Wolfe St. Baltimore, MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>3/8/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>				25a. DATE RECEIVED BY REGISTRY <b>MAR 7 1984</b>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06873

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCES B. FRANKOWSKI</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 20, 1984</b>		2b. HOUR <b>10:05 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 2 1898</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AGNES JANDOWSKI</b>		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		17b. SOCIAL SECURITY NO. <b>219 030579</b>		17c. INFORMANT ADDRESS <b>AGNES TALTY'S 1363 E. NORTHERN PKWY.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS (OCCULT)</b> <b>5315</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL EFFUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>PERFORATED LARGE GASTRIC ULCER, PERITONITIS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION <b>MARCH 11, 1984</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATED GASTRIC ULCER</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>MARCH 11, 1984</b> to <b>MARCH 20, 1984</b> , that (1) we last saw the deceased alive on <b>MARCH 20, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.					
22b. SIGNATURE <i>Simpson</i>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Simpson</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD. 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/24/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR <b>MARCH 22, 1984</b>		23f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Raymond L. KACZOROWSKI 2525 FLEET ST.</b>					

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



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REPORT OF  
OFFICER  
NAME  
RICHARD J. [illegible]  
Baltimore  
10 2 1968  
WHITE  
Baltimore City  
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REMARKS  
[illegible text]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06874

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET R. FRANKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 4, 1984</b>		2b. HOUR <b>4:55 PM</b>				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 6 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home &amp; Hosp</b>				12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.B.M.C</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Parkville</b>		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7837 DANIELS AVE 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS REDDING</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLEN KERR</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-24-5558</b>		17. INFORMANT		ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ESCHERICHIA COLI SEPTICEMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5990 DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY TRACT INFECTION (PROBABLY)</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**CERBROVASCULAR ACCIDENT PNEUMONIA**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) <del>did not</del> view the deceased from <b>FEBRUARY 25, 1984</b> , to <b>MARCH 4, 1984</b> , that <del>xx</del> last saw the deceased alive on <b>1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN <b>AHMED NOUR</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/19/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AHMED NOUR</b>		22e. ADDRESS <b>CHURCH HOSPITAL 100 NORTH BROADWAY 21231</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-7-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>Evans Chapel of Memories</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

27 MAY 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

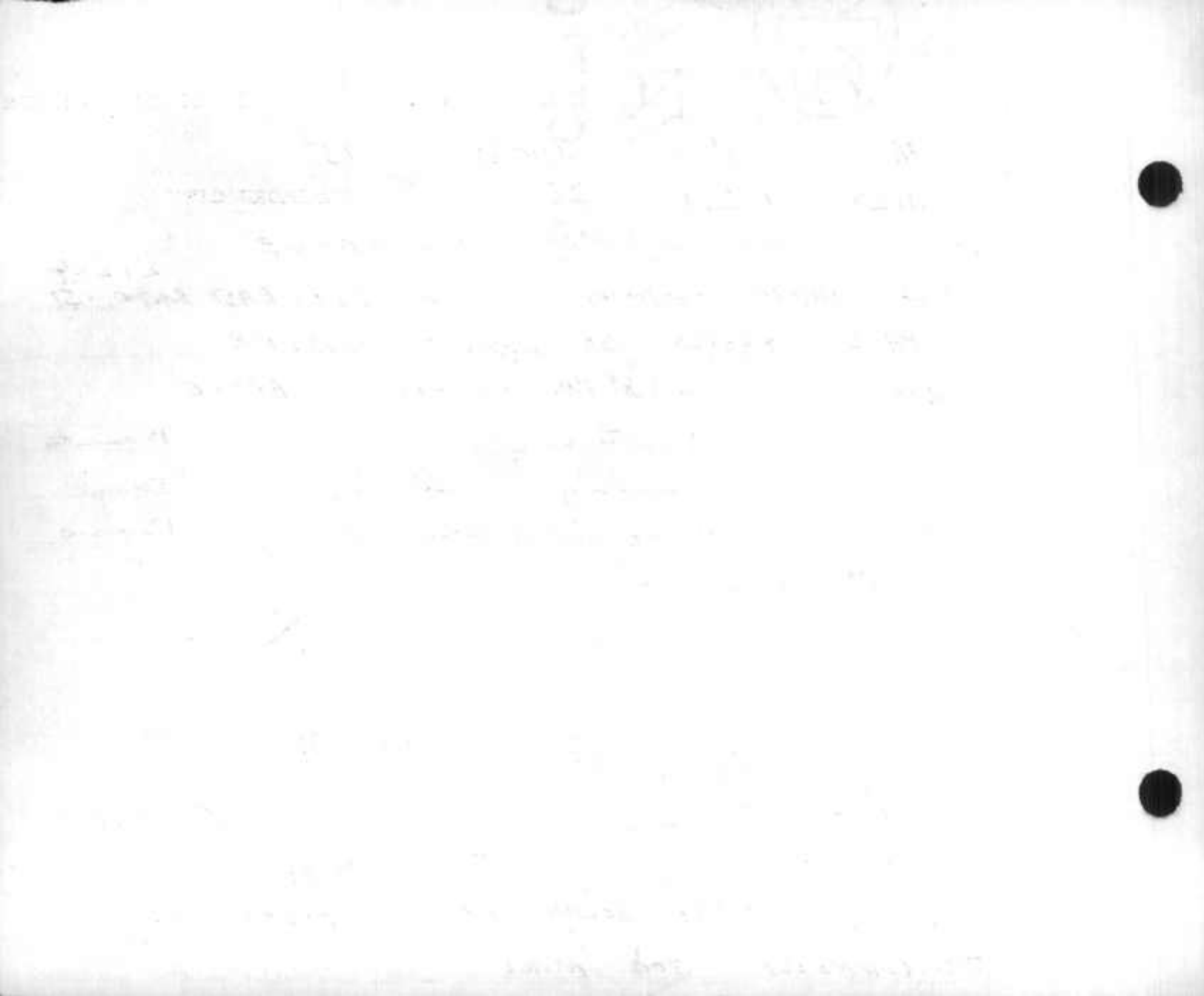
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on or before 24 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PAUL FREELS JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 03 84</b>			2b. HOUR <b>6:10PM</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/10/68</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>15</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>				
12. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>MD.</b>			16b. COUNTY <b>BALTO</b>		16c. CITY OR TOWN <b>EASTPOINT</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>7943 EAST BALTO. ST 21244</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>PAUL FREELS SR.</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NANCY SISLER</b>							
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			20. SOCIAL SECURITY NO. <b>218 88 7569</b>			21. INFORMANT ADDRESS <b>FATHER ABOVE</b>				
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>3439</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe cerebral palsy</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>5 days</b> <b>12 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Malnutrition</b>										
23a. DATE OF OPERATION			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED			24a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
26a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			26c. LOCATION STREET CITY OR TOWN COUNTY STATE				
27. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> 19 <b>84</b> , to <b>3/3</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/3</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
28a. SIGNATURE <b>R Scott Strahman</b>			28b. DEGREE <b>MD</b>			28c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		28d. DATE SIGNED <b>3/3/84</b>		
29a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R S Strahman</b>			29b. ADDRESS <b>Johns Hopkins</b>							
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			30b. DATE <b>3/6/84</b>		30c. NAME OF CEMETERY OR CREMATORY <b>BELAIR CEM.</b>		30d. LOCATION CITY OR TOWN COUNTY STATE <b>BELAIR MD.</b>			
31. FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b>			31b. ADDRESS <b>300 MACE</b>			31c. DATE REC'D. BY REGISTRAR <b>MAR 9 1984</b>		31d. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 only should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth G. M. Freese				2a. DATE OF DEATH MONTH 3 DAY 5 YEAR 84		2b. HOUR 1:55 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 10 DAY 23 YEAR 28		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. MARYLAND Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESEARCH		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13a. COUNTY Montgomery 13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8300 Whitman Dr. 20817		
14. FATHER'S NAME FIRST BAUTZ, MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST WISE, MIDDLE PLUCK, LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 020-32-5242		17. INFORMANT ADDRESS 20817 DR. ERNST FREESE-8300 WHITMAN DR BETHESDA MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC OAT CELL CA. 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Intrav. Coagulation 2/23/84 - 3/5 DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2/23/84 - 3/5
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2/23/84, 1984, to March 5, 1984, that (I) (we) lost saw the deceased alive on March 5, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Hector Silva		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/5/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hector Silva		22e. ADDRESS UNIV. MARYLAND Hospital, BALTO, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE March 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Rock Creek.		Washington, D. C. STATE
24. FUNERAL DIRECTOR Takoma Funeral Home, Inc. 254 Carroll St. N. W. D. C.		25. RECEIVED BY MAR 8 1984 John Davidson-Russell				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 06877		
1. DECEASED NAME (TYPE OR PRINT) <b>FREY, KATHERINE L.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-3-84</b>		2b. HOUR <b>8 AM</b>		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-2-1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. STREET ADDRESS <b>4139 HAGUE AVE.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES C. TRAVERS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA M. DUNN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-30-3394</b>		17. INFORMANT ADDRESS <b>4141 Hague Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory distress</b> <b>5325</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>abdominal surgery, abscess</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>perforated duodenal ulcer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION <b>2/14/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>perforated duodenal ulcer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, WARS, OR OTHER CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:30 P.M. 3/3/84</b>		21c. LOCATION OF INJURY CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> , 19 <b>84</b> , to <b>3/3</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/3/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>McLwin J. Packer MD</b>				22e. ADDRESS <b>Mercy Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-6-84</b>		23c. NAME OF CEMETERY OR INTERMENT PLACE <b>BALTO. NATIONAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>David R. Randle</b> ADDRESS <b>-7527 Hanford Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1984</b>		25b. REGISTRAR'S SIGNATURE <b>David R. Randle</b>	

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James C. Thompson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06878

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ROSE				FRIEDMAN	March		6	1984		11:37 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		APR. 28, 1912		71		MONTHS		DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE		CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE CITY		NORTH CHARLES GEN. HOSP.				HOUSEWIFE		AT HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		1ST. FL.	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3911 PINKNEY RD.		21215	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
SAMUEL STARK				BESSIE BLUM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1ST FL.					
NO		213-01-1651		ISADORE FRIEDMAN		3911 PINKNEY RD. BALTO., MD		21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> <u>1749</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wide-spread Terminal CA.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast CA.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) <u>Pleural Effusion</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 28, 1984</u> to <u>March 6, 1984</u> , that (I) (we) lost saw the deceased alive on <u>March 4, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Regino L. Garcia, M.D.</u>				DEGREE				22c. DATE SIGNED <u>3/6/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Regino L. Garcia, M.D.</u>				22e. ADDRESS <u>NCGH - 28th &amp; N. Charles St. Baltimore, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		MAR. 7, 1984		BALTIMORE HEBREW CEM		BALTIMORE		COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Juha Davidson-Randall</u>			
						MAR 9 1984					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy CATHERINE FRIZZELL</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-18 1984</b>		2b. HOUR M <b>7:41</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 2 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3-18 19 84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>19 N. Wickham Road</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19 N. Wickham Road 21229</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles F. Geckle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna A. Long</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-20-2500</b>			17. INFORMANT ADDRESS <b>Charles Reckard 512 Brisbane Rd. 21229</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging</b> <b>9530</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 3-18 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject hung herself</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Hospital</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>19 N. Wickham Rd., Balto., Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. <b>Assistant</b>				DATE SIGNED <b>3-19-84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/21/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson</i>			

BP

SECRET

CONFIDENTIAL

CONFIDENTIAL





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 6 8 8 0

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Samuel Fulton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1984</b>			2b. HOUR <b>9:10PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Fulton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Celie Felder</b>		13e. STREET ADDRESS / ZIP CODE <b>2400 Liberty Heights Ave. 21215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-30-8046</b>		17. INFORMANT ADDRESS <b>Rachael V. Gordon 2400 Liberty Hgts. Ave.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <b>Arteriosclerotic Heart Disease And</b>	
	(c) <b>of Extensive Pulmonary Fibrosis</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  
**Severe Pulmonary Fibrosis and Acute and Chronic Respiratory Failure due to Acute Renal Failure**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 17, 1984</b> , to <b>March 3, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 3, 1984</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>JOSEPH NKWANYUO MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH NKWANYUO</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>			

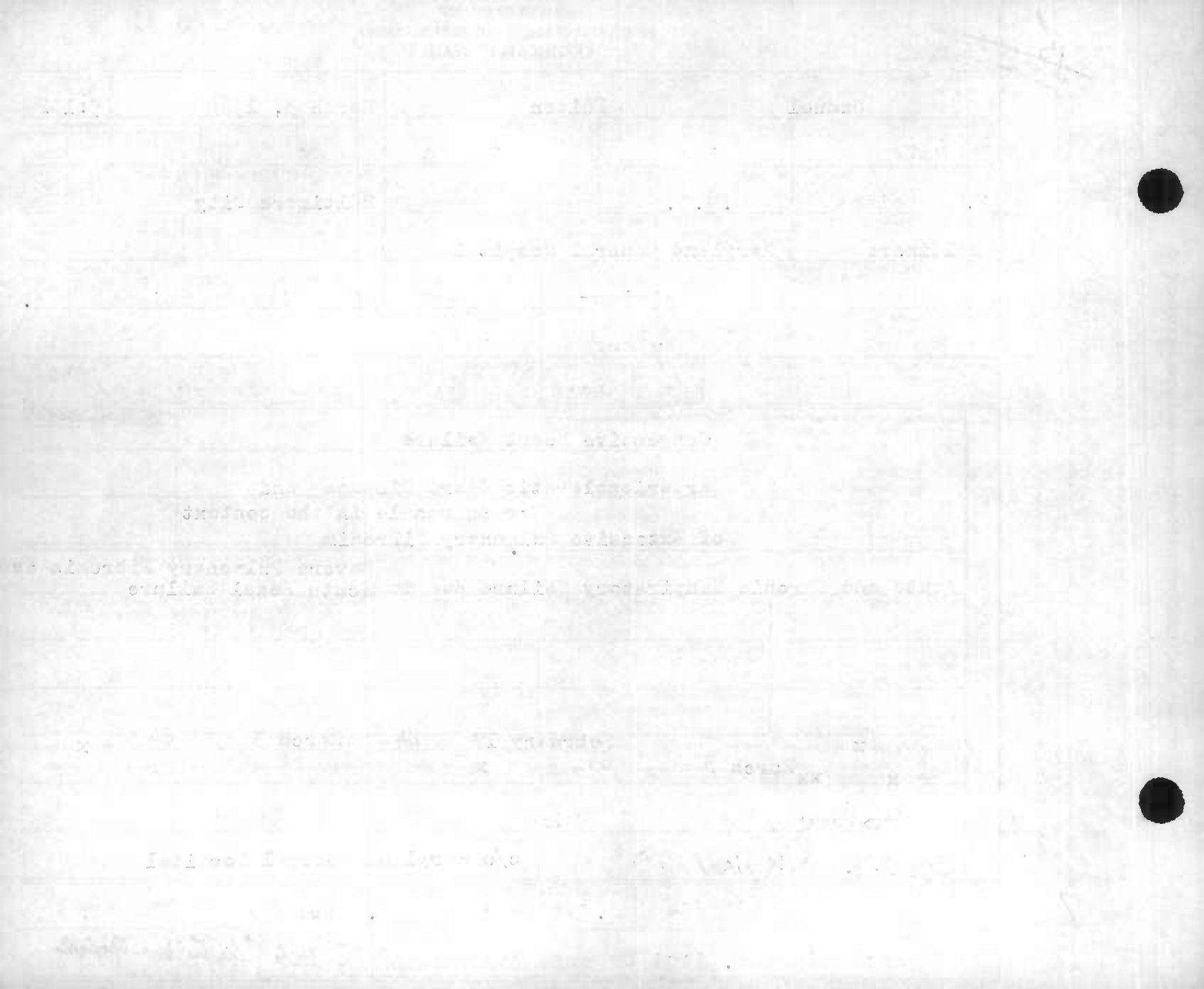
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/10/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 05 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR WILLIAM CARR FULTON, JR. CERTIFICATE OF DEATH				REG. NO. 06381			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM CARR FULTON, JR.				2a. DATE OF DEATH MONTH DAY YEAR 03 27 84			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 28 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MUSICIAN		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM CARR FULTON, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE ELIZABETH WINTERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS DEBORAH L. CLUTTER 18 AVON AVENUE 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RENAL CELL CARCINOMA METASTATIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/28, 19 84, to 3/27, 19 84, that (I) (we) last saw the deceased alive on 3/27, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Yang		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3-27-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW YANG M.D.		22e. ADDRESS BALTIMORE CITY HOSPITAL 4540 EASTON AVE.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/30/1984		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY, MD	
24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC. DUNDALK, MD 21222				25a. DATE REC'D. BY REGISTRAR MAR 28 1984			
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 must also be marked. Item 18 must be marked if there is any injury, or other traumatic event, the medical examiner is notified at death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06882

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM TIMOTHY GALES			2a. DATE OF DEATH MONTH DAY YEAR 3/26/84		2b. HOUR 11:33 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 09 29 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT	12b. KIND OF BUSINESS OR INDUSTRY BUSINESS
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 124 W. FRANKLIN ST. 21201	
14. FATHER'S NAME FIRST MIDDLE LAST TIMOTHY WILLIAM GALES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALYCE COZZENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-09-6817	17. INFORMANT JACKIE GALES		ADDRESS 430 WESTSHIRE DR. CATONSVILLE MD 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension, Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis GI Bleeding</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Cirrhosis of Liver</u>					
19a. DATE OF OPERATION 3/14/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Upper Gastrointestinal Bleed		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 3/16/84 to 3/26/84, that (we) lost saw the deceased alive on 3/23/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles White MD.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CHARLES WHITE MD.		22e. ADDRESS 900 CATON AVE			
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL	23b. DATE 3-29-84	23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VET. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE GARRISON BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS FLEET CITY BALTIMORE 21201		25a. DATE REC'D. BY REGISTRAR APR 6 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06883			
1. FOR STATE REGISTRAR							
I. DECEASED NAME [TYPE OR PRINT] FIRST MIDDLE LAST DONALD F. GALLAGHER SR.				2a. DATE OF DEATH MONTH DAY YEAR 03 01 84			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 17 29		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3591 BENZINGER ROAD, 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY CITY OF BALTO.	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER G. GALLAGHER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE J. Fahrman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1947-1951		17. INFORMANT ADDRESS DENNIS P. GALLAGHER 3623 MacTAVISH AVENUE 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-Respiratory Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Heart Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Cirrhosis of Liver</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 23</u> , 19 <u>83</u> , to <u>Present</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>22 PM Feb 7 84</u> , 19 <u>84</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stanley L. Minken M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 3-2-84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY L. MINKEN, M.D.	
22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-05-84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND		23e. NAME OF FUNERAL DIRECTOR HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.		23f. ADDRESS 21229		23g. DATE REC'D. BY REGISTRAR MAR 6 1984	
23h. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06884			
1. DECEASED NAME (TYPE OR PRINT) <u>George Galloway</u>				2a. DATE OF DEATH MONTH <u>03</u> DAY <u>18</u> YEAR <u>84</u>			
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>07</u> DAY <u>16</u> YEAR <u>05</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>(City) Baltimore</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mary Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS <u>21202</u>			
13a. STATE <u>MD</u>		13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST — MIDDLE — LAST —				15. MOTHER'S MAIDEN NAME FIRST — MIDDLE — LAST —			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNKNOWN</u>		16b. SOCIAL SECURITY NO. <u>213-20-3176</u>		17. INFORMANT ADDRESS <u>St. Paul Burno 1100 Abbott Court</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>5849</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute renal failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>(this hospital)</u> attended the deceased from <u>3-14</u> , 19 <u>84</u> , to <u>3-18</u> , 19 <u>84</u> , that <u>he</u> <u>(we)</u> lost <u>saw</u> the deceased alive on <u>3-18</u> , 19 <u>84</u> , and that in <u>my</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
22b. SIGNATURE <u>Jeannine L. Saunders MD</u> PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-18-84</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>3/23/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Cem.</u>		23d. LOCATION <u>Lansdowne,</u> COUNTY <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H Inc.</u> ADDRESS <u>1101 E North Avenue</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 22 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

20% COTTON

CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

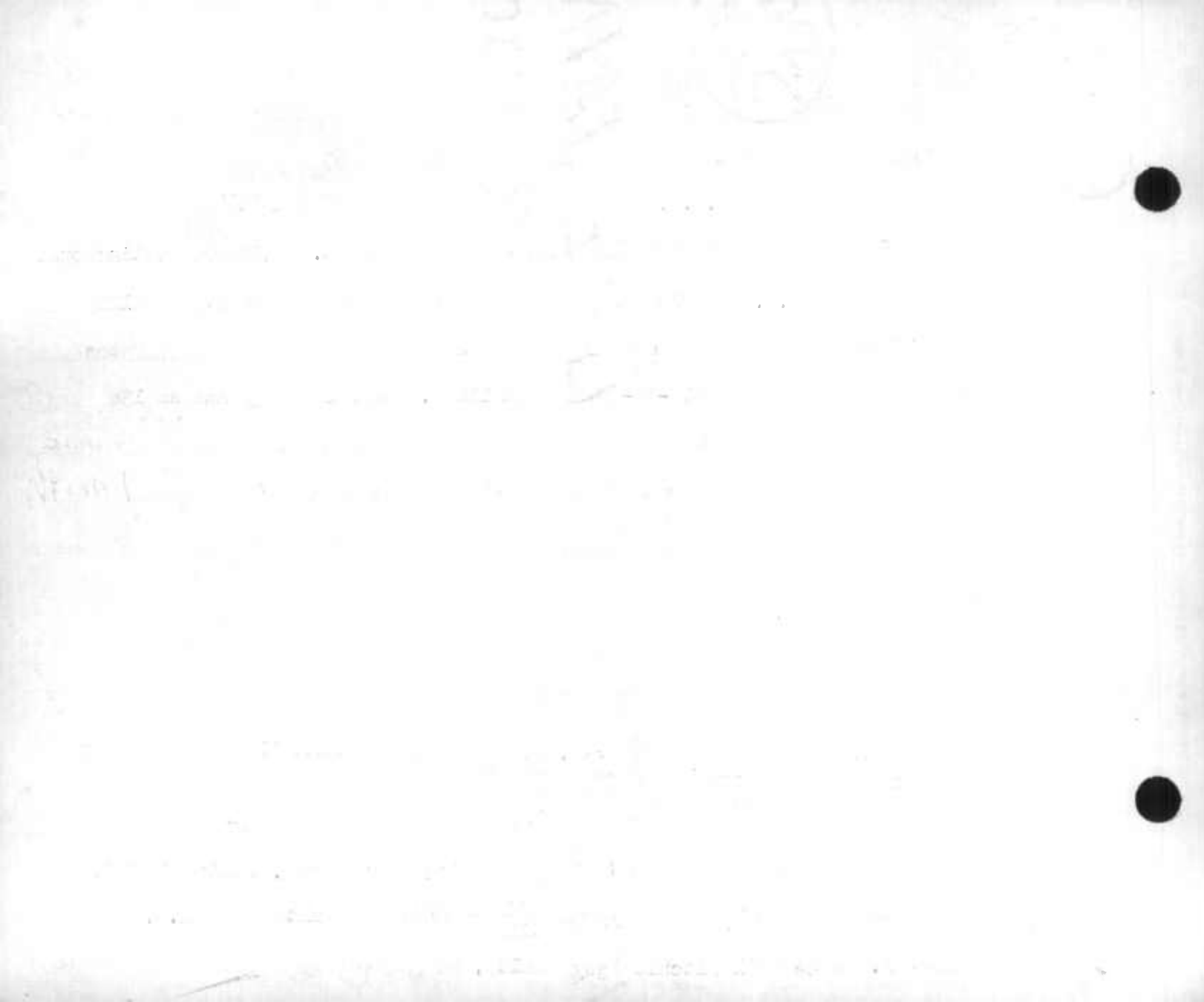
06885

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEROY D GARDNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 11, 84</b>		2b. HOUR <b>9:50p M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 5 20</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO MD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maint. Engineer</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>		13a. STATE <b>Md</b>		13b. COUNTY <b>A.A.</b>		
13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5409 Wasena Ave 21225</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Gardner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Upton</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 213-16-6942</b>		17. INFORMANT ADDRESS <b>Stella M. Gardner Same as 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cadio - pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 miles</b> <b>1 month</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (X) (this hospital) attended the deceased from <b>Feb. 22</b> , 19 <b>84</b> , to <b>March 11</b> , 19 <b>84</b> , that (X) (we) lost sight of the deceased after on <b>March 11</b> , 19 <b>84</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (and) (X) (we) view the body of the deceased.				
22b. SIGNATURE <b>CES heehun MD</b>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CES heehun MD</b>		
22e. ADDRESS <b>3900 Loch Raven Blvd. Balto Md 21218</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				
23b. DATE <b>3/15/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto A.A. Md</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy Balto, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

BP



FOR  
1- STATE F#599  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT L. GARDNER III</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>3-26-84</b>			2b. HOUR <b>9:22A</b>								
3. SEX <b>male</b> RACE <b>Col</b>		5. DATE OF BIRTH <b>2-17-84</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1</b> YRS. <b>8</b> MONTHS <b>1</b> DAYS <b>8</b> HOURS <b>0</b> MIN.		2c. DATE PRONOUNCED DEAD <b>3-26-84</b>			2d. HOUR <b>9:22A</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baby</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>			13b. COUNTY			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>22 N. Carey St 21228</b>		
14. FATHER'S NAME <b>ROBERT L. GARDNER</b>						15. MOTHER'S MAIDEN NAME <b>Valerie Falls</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT ADDRESS <b>Mrs Valerie Falls 22 N. Carey St 21223</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Cardiomyopathy</b> IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <b>Margareta Meyhall</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>3-26-84</b>						
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>										
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>				23b. DATE <b>3-31-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT ZION CEM</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOWNE BALTO CO. MD</b>				
24. FUNERAL DIRECTOR NAME <b>JOSEPH L. RUS</b> ADDRESS <b>2224 W. NORTH AVE</b>								25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b>						
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>														

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06887

1- FOR STATE REGISTRAR

REG. NO.

I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
THOMAS GAROS

2a. DATE OF DEATH MONTH DAY YEAR  
3 22 84

2b. HOUR  
7:33P M

3. SEX  
Male

4. RACE  
White

5. DATE OF BIRTH MONTH DAY YEAR  
May 26, 1923

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS  
60

7. IF UNDER 1 YEAR IF UNDER 24 HRS  
MONTHS DAYS HOURS MIN.

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Pennsylvania

9. CITIZEN OF WHAT COUNTRY?  
U.S.A.

10. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

11. BALTIMORE CITY OR COUNTY OF DEATH  
BALTIMORE, CITY MD.

12. CITY OR TOWN OF DEATH  
Baltimore

13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
VAMC, BALTIMORE, MD. 21218

14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Chef

15. KIND OF BUSINESS OR INDUSTRY  
Restaurant

16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
17a. STATE  
Maryland

17b. COUNTY  
Baltimore

17c. CITY OR TOWN  
21221

17d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

17e. STREET ADDRESS / ZIP CODE  
1610 Gail Road 21221

18. FATHER'S NAME FIRST MIDDLE LAST  
Foma Garos

19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Mary Kushner

20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
Yes W.W. II

21. SOCIAL SECURITY NO.  
169-16-4225

22. INFORMANT  
K. Robin Cook

23. ADDRESS  
9116 Waltham Woods Rd. 21223

24. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cardiopulmonary arrest  
5728  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:  
(b) gt bleedg 2° coagulopathy 2°  
(c) hepatic failure 2° alcoholic cirrhosis 2° alcoholism  
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

25. DATE OF OPERATION  
19. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20a. AUTOPSY?  
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that ☒ (this hospital) attended the deceased from 3/13, 19 84, to 3/22, 19 84, that ☒ (we) lost ☐ (we) (did) ☒ view the body after death.  
above, ☒ (we) (did) ☒ view the body after death.

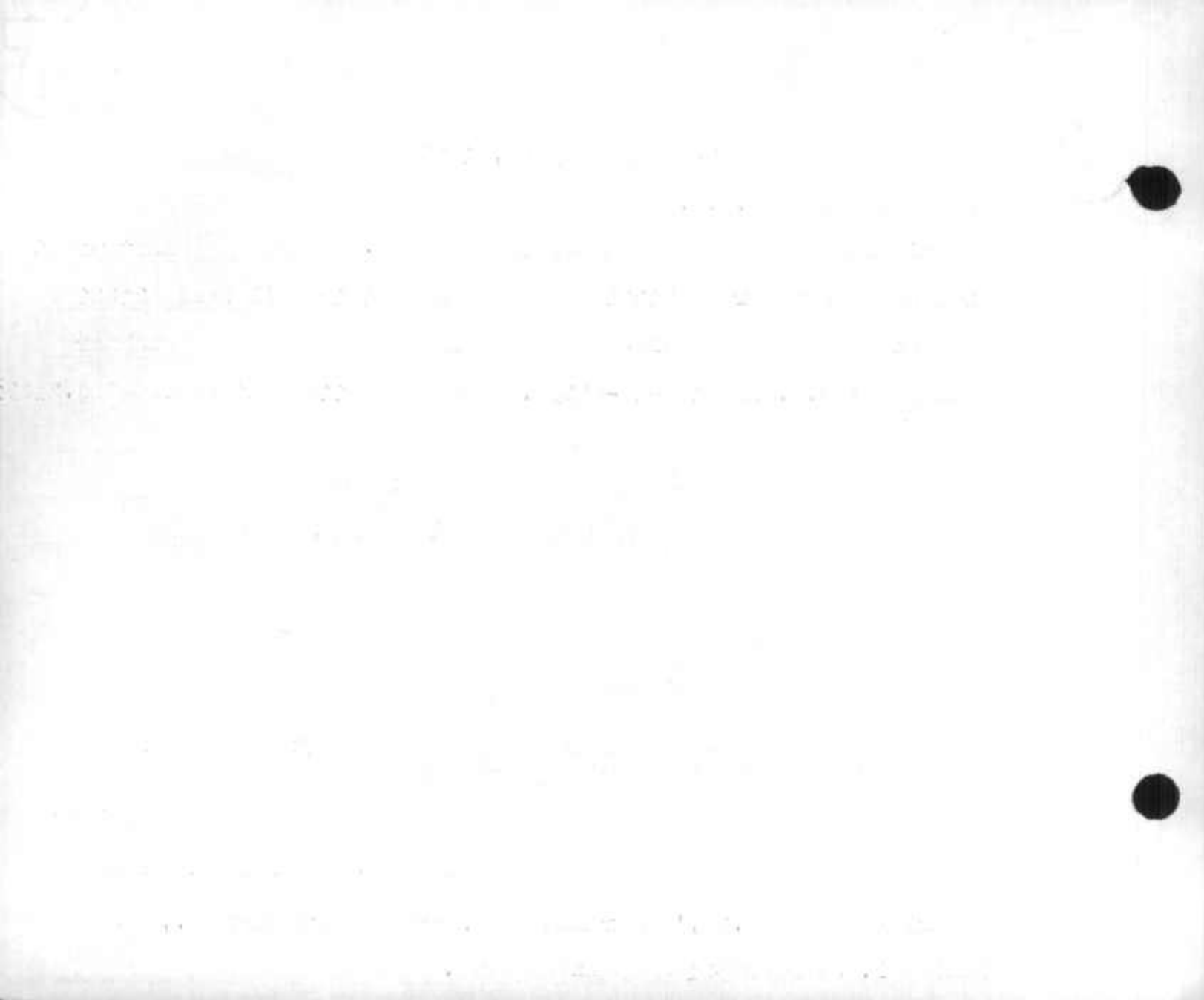
22b. SIGNATURE  
Ralph J. Panos MD  
DEGREE  
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
3/23/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
RALPH J. PANOS MD  
22e. ADDRESS  
3900 LOCH RAVEN BLVD. BALTO. MD. 21218

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial  
23b. DATE  
Mar. 24, '84  
23c. NAME OF CEMETERY OR CREMATORY  
Moreland Mem. Park  
23d. LOCATION CITY OR TOWN COUNTY STATE  
Baltimore Co., MD

24. FUNERAL DIRECTOR NAME ADDRESS  
William E. Johnson 8521 Loch Raven Blvd.  
25. DATE REC'D. BY REGISTRAR  
MAR 23 1984  
26. REGISTRAR'S SIGNATURE  
John Davidson-Hendell



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST KATHERINE ANNA GARRETT		MONTH DAY YEAR March 1, 1984	
3. SEX FEMALE			4. RACE CAUCASIAN		2b. HOUR 3 <sup>15</sup> P.M.	
5. DATE OF BIRTH MONTH DAY YEAR 3 / 22 / 1894			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. Baltimore General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. STATE MONTGOMERY			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Linthicum	
14. FATHER'S NAME FIRST MIDDLE LAST John Lein Eweger John Leineweber			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Katherine Berger		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no			16b. SOCIAL SECURITY NO. 213-03-5137		17. INFORMANT Mrs. Mary Grantland Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HASCVD and mitral valvular 4029 DUE TO, OR AS A CONSEQUENCE OF (b) endocarditis. DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that N (this hospital) attended the deceased from December 28, 1983, to March 1, 1984, that N (we) lost saw the deceased alive on March 1, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, N (we) (did) (did not) view the body after death.						
22b. SIGNATURE James T. Heiser, M.D.				DEGREE		22c. DATE SIGNED 3/1/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James T. Heiser, M.D.				22e. ADDRESS 3001 S. Hanover Baltimore MD 21230		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co., Md.
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				25a. DATE REC'D. BY REGISTRAR MAR 5 1984		
25b. REGISTRAR'S SIGNATURE John Davidson						

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

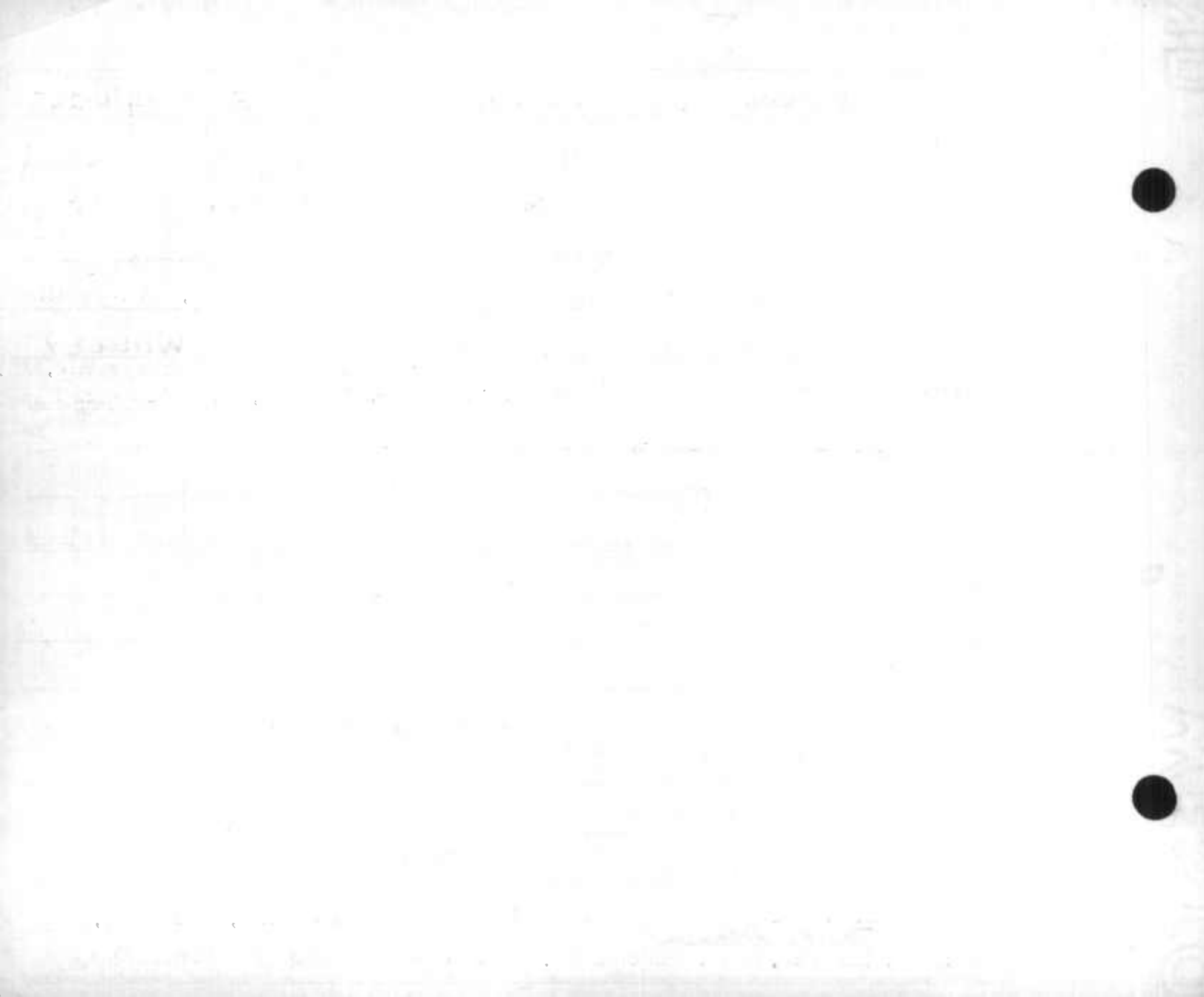
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) <b>EUGENE Debs GASKINS</b>					2b. MONTH DAY YEAR <b>3 3 84</b>				
3 SEX <b>Male</b>					2b. HOUR <b>12:24 P.M.</b>				
4 RACE <b>White</b>					5 DATE OF BIRTH				
5 DATE OF BIRTH MONTH DAY YEAR <b>November 17, 1906</b>					6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Deck officer</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>				
13a. STATE <b>Maryland</b>					13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13c. COUNTY <b>Baltimore</b>					13d. STREET ADDRESS <b>1113 Justa Lane, Cockeysville</b>				
13e. CITY OR TOWN <b>Cockeysville</b>					14. FATHER'S NAME				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Harris Gaskins</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Carey WHEELY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>					16b. SOCIAL SECURITY NO. <b>213-10-4718</b>				
17. INFORMANT (21030) ADDRESS <b>Cockeysville, Md.</b>					17. INFORMANT (21030) ADDRESS <b>Mr. Eugene D. Gaskins, Jr. 1113 Justa Lane</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Respiratory arrest - 2° Cardiac arrest</b>									
5070 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration Pneumonia</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>SPRING GROVE HOSPITAL CENTER</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/4/78</b> 19 <b>78</b> to <b>3/3/84</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/3/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. E. GONWALD</b>			DEGREE			22c. DATE SIGNED <b>3/3/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. E. GONWALD</b>			22e. ADDRESS <b>SEHC.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>3/6/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Baltimore, Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b> ADDRESS <b>10 W. Padonia Rd. Timonium</b>						25. DATE REC'D. BY REGISTRAR <b>MAR 5 1984</b>		25. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

U 6 8 7 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>29</b> YEAR <b>84</b>			2b. HOUR <b>5:55 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>27</b> YEAR <b>22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SO. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> <b>Maryland, MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISABLE</b>		12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1111 Sarah Ann St 21223</b>	
14. FATHER'S NAME FIRST <b>HENRY</b> MIDDLE <b>GATSON</b> LAST <b>PENN</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Lula</b> MIDDLE <b>PENN</b> LAST <b>PENN</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>			
16a. SOCIAL SECURITY NO. <b>248-34-7916</b>			17. INFORMANT <b>MR Robert Boyd</b>			ADDRESS <b>ST Joseph ST (Nephew)</b>			

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: <b>4100</b>		IMMEDIATE CAUSE (a) <b>Possible acute myocardial infarct.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b>			
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>ISCVD</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Hypertension; Peritonitis; arrhythmia 2° ASCVD**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **3/29**, 19 **84**, to **3/29**, 19 **84**, that (I) (we) lost  
saw the deceased alive on **3/29**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (We) (I) did not view the body after death.

22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN A. BELTRAN</b>		22e. ADDRESS <b>1940 W. BALTIMORE ST BALTO MD</b>			

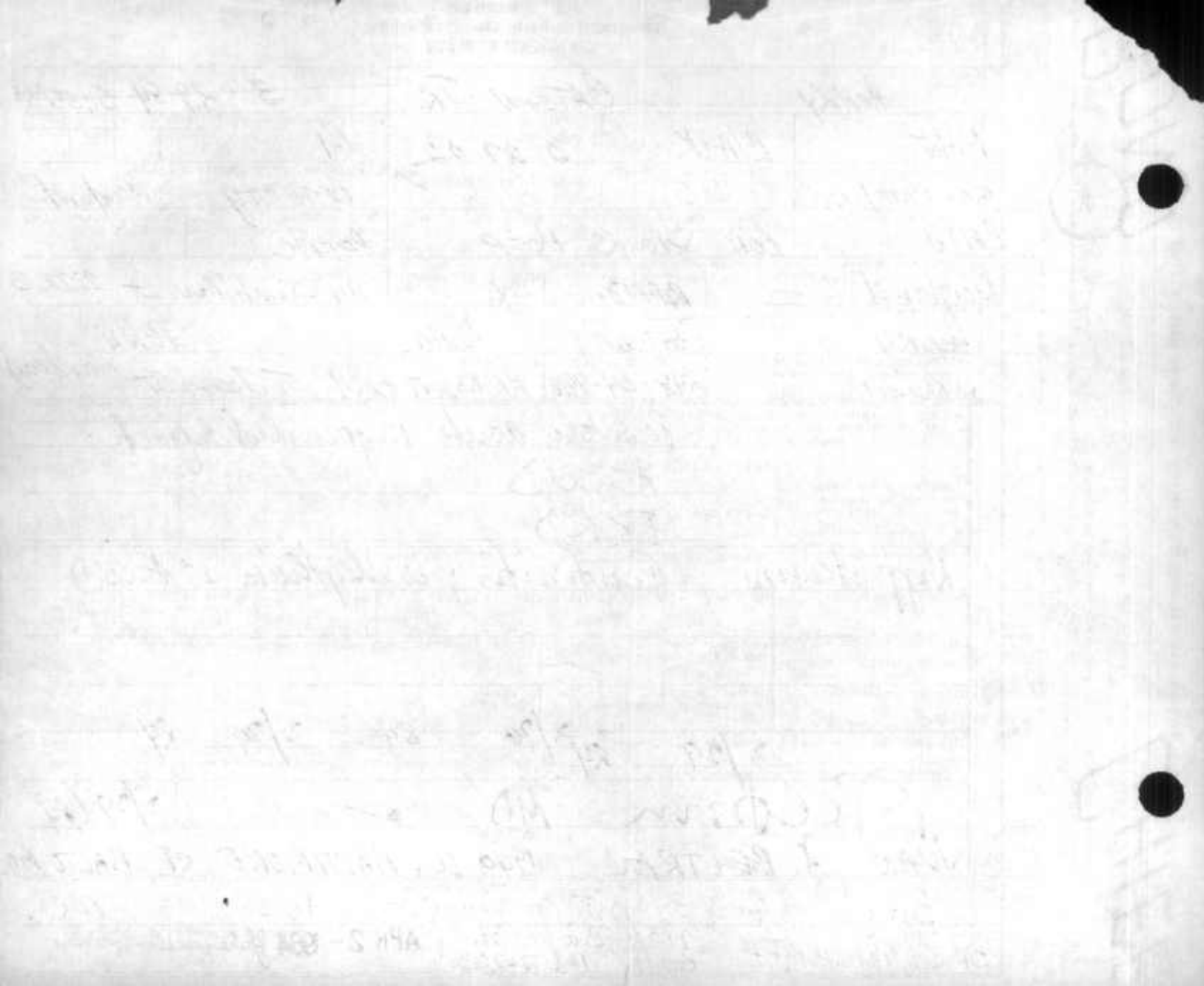
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-3-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>Brown/Thompson FH.</b>		ADDRESS <b>1913 W. Baltimore St. Balto., Md 21223</b>		25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>APR 2 - 1984</b> <b>Juan Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Other," it shows other injury, or other traumatic event, the medical examiner should be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lucille Mary Gaudet</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>03 04 84</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 07 98</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lake Charles LA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	
9. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SC Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Housemother</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Mollie Hogan</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>149 16 5106 A</b>		17. INFORMANT <b>Miss Juanita Norris</b>		17. ADDRESS <b>Arnold Md 21012 Driftwood Ct</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>2041</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEIZURES, ATRIAL FIBRILLATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROBABLE CLL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE OF PHYSICIAN <b>Gaush Malhotra</b>				22c. DATE SIGNED <b>3-4-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAKESH MALHOTRA</b>				22e. ADDRESS <b>ST AGNES HOSPITAL, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 7'84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Gertrude</b>	
24. FUNERAL DIRECTOR <b>Harry H Witzke</b>		24b. ADDRESS <b>4112 Columbia RD Ellicott City</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>Richard Randall</b>					

BP \_\_\_\_\_

2

Baltimore

50 Avenue Hospital

REC'D Housemother

U.S.A.

x

Baltimore City

Maryland Howard

McCormick

Late Hollis Gorman

late

149 16 Side A Miss Lillian Morris 1210 Willow St

Arnold Rd 21012  
1210 Willow St

Burial

March 7, 1954 St Gertrude

Bayway New Jersey

Harry H Wieseke 4112 Columbia Rd Ellwood City

MAR 5 1954

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Frank Joseph Gayoski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-20-84</b>			2b. HOUR <b>2:05</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 04 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>89</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN <b>2:05</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supply Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5510 Frederick Avenue, 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Gayoski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I 168-12-8809</b>		17. INFORMANT ADDRESS <b>Jane Gayoski 5510 Frederick Avenue, 21228</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a)

ENCEPHALOPATHY DIFFUSE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) CEREBROVASCULAR ACCIDENT

DUE TO, OR AS A CONSEQUENCE OF

RIGHT HEART FAILURE

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) [this hospital] attended the deceased from <u>3/20</u> 19 <u>84</u> to <u>3/20</u> 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <i>E. Kasaitis</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/20/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. KASAITIS, M.D.</b>				22e. ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>03-23-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1984</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100-100

BALTIMORE CITY

ST. JOHNS HOSPITAL

BALTIMORE

000 EIGHTH AVE. BALTIMORE, MD. 21208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					MONTH DAY YEAR					M	
GRACE Q. GEBELEIN					March 21, 1984					7P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		May 5, 1896		87 YRS		MONTHS DAYS		HOURS MIN.	
7a. PLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Keswick Home				Homemaker		Own Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY					13c. CITY OR TOWN	
MD					Baltimore					21212	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Henry Quarngesser					Maggie M. Stewart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					219 16 4828		Paul J. Gebelein, Jr., Balto., MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral atherosclerosis (encephalomalacia)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 29</u> , 19 <u>82</u> , to <u>March 21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/21/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death.											
22b. SIGNATURE <u>W.B. Daniels, Jr.</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>3/21/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
W.B. Daniels, Jr.				Keswick, 700 W. 40th, Balto 21211							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3/26/84		Druid Ridge		Pikesville, MD					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212						MAR 23 1984		<u>Frederick Randall</u>			

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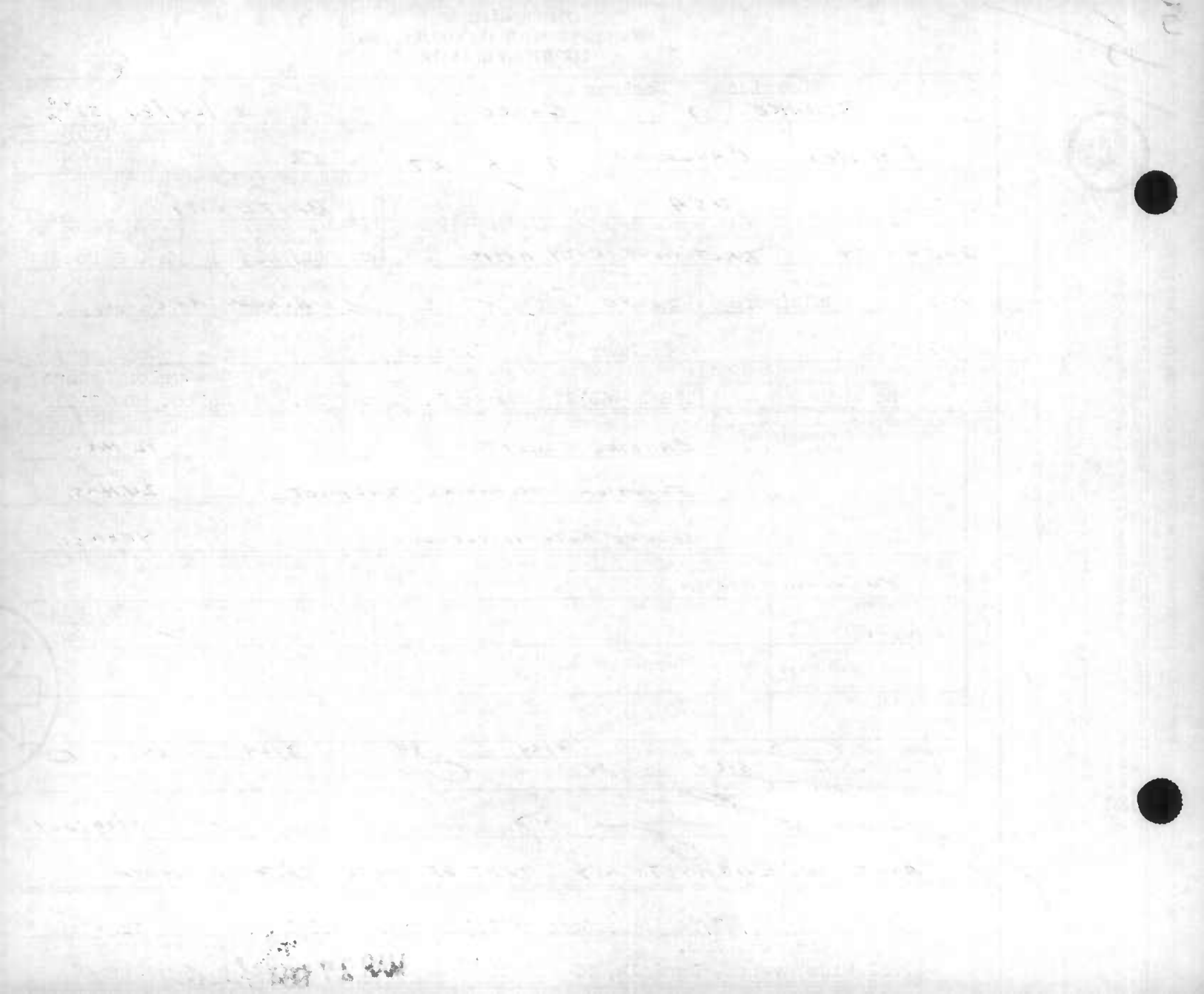


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Bernice Dashner Genco BERNICE DASHNER GENCO				3 12/24/84 5 40 A M			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 3 27		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD	
10. CITY OR TOWN OF DEATH BALTO CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wrapper/Weigher		12b. KIND OF BUSINESS OR INDUSTRY A & P Food	
13a. STATE MD				13b. CITY OR TOWN BALTO		13c. STREET ADDRESS 60 AVALON AVE 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Dashner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Collins		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 216-20-4618		17. INFORMANT Casper J. Genco, Sr.		ADDRESS 60 Avalon Avenue Balto. MD 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a). CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b). INFARCTION MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c). SEVERE ARTERIOSCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 HR. 24 HRS. YEARS.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PULMONARY EDEMA							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 3/24 19 84 to 3/24 19 84, that (I) (we) lost the deceased alive on 3/24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) examine the body after death.							
22b. SIGNATURE JAMES W. EAGAN, JR. MD				DEGREE MD		22c. DATE SIGNED 3/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EAGAN, JR. MD				22e. ADDRESS DEPT OF PATH, BALTO CITY HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/27/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR MAR 27 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Bond			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

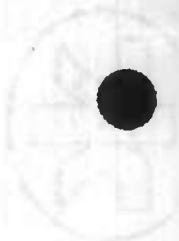
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA M. George</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>84</b>		2b. HOUR <b>5:10 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>02</b> DAY <b>14</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALT</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b></b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b></b> LAST <b>Spencer</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Not Known</b> MIDDLE <b></b> LAST <b>GORBY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO Unknown</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>234 18 057</b>		17. INFORMANT ADDRESS <b>Velma Osborne 226 Colgate Ave. 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BACTEREMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>84</b> , to <b>3/13</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>MARIE AMOS Dobyns</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIE AMOS DOBYNS</b>		22d. ADDRESS <b>MERCY HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-8-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church of Christ</b>	
24. FUNERAL DIRECTOR NAME <b>Duda Ruck, inc.</b> ADDRESS <b>7922 Wise Ave. Balto., Md. 21222</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Shirley Tyler W. Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1984</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



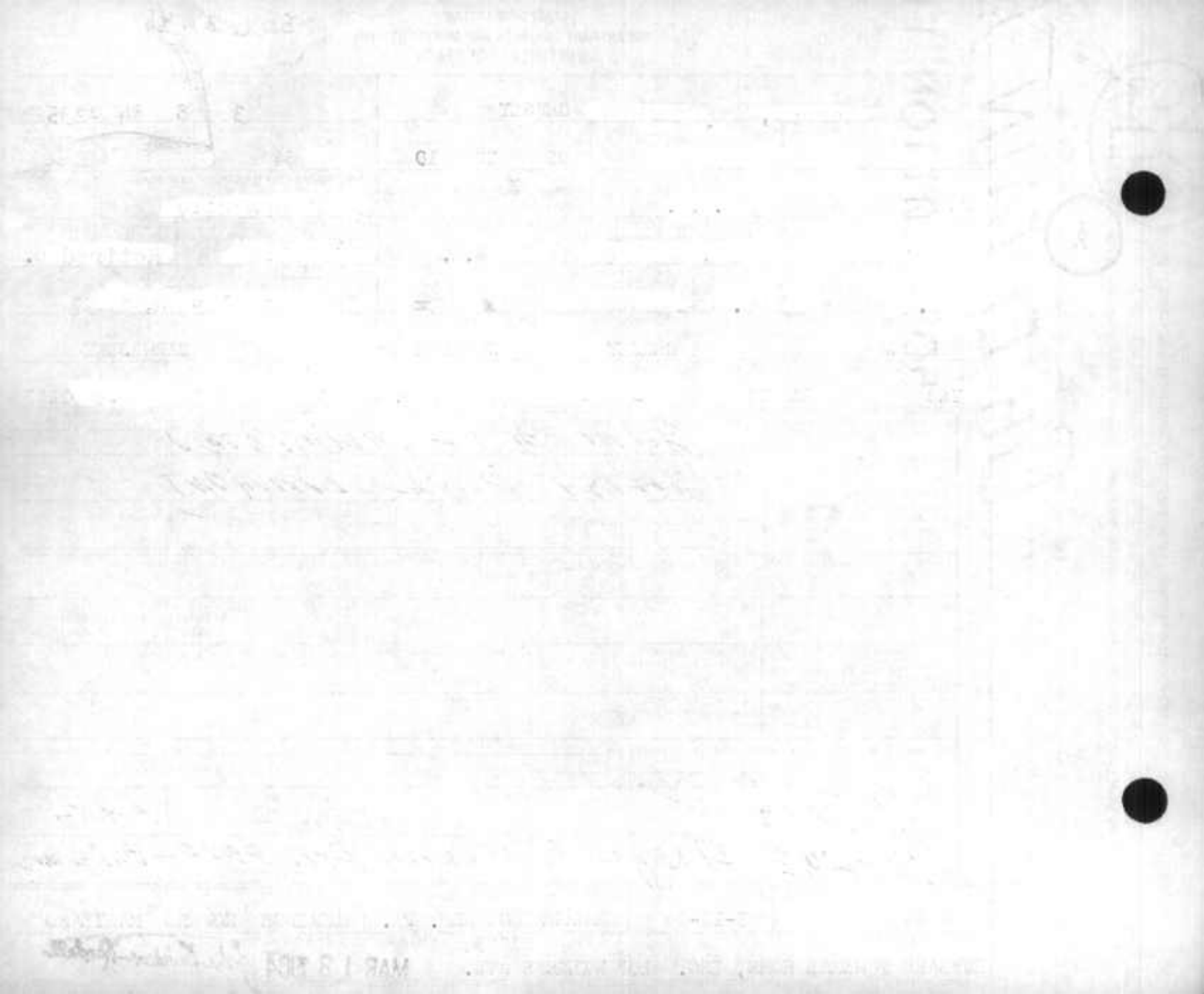
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06896			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 8 84			
1. DECEASED NAME FIRST MIDDLE LAST STEPHEN JOSEPH GERSEY				2b. HOUR 2235 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 22 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL E.R.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WORKER		12b. KIND OF BUSINESS OR INDUSTRY ELEVATOR CO.	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANSOWNE	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW GERSEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE BARWEJSKY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 218-10-2214		17. INFORMANT ADDRESS ROSELLER M. GERSEY 3208 STANLEY RD., 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-9-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE ANOC				22e. ADDRESS Wilkins Dr. 3350 - Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-12-84		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. ADDRESS 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Mar 12 1984 Julia Davidson-Rendall			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN W GILBERT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 18 84</b>		2b. HOUR <b>1:35a<sub>M</sub></b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENNESSEE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC BALTIMORE, MARYLAND 21218</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>414 38 9524</b>		17. INFORMANT ADDRESS <b>VA MEDICAL RECORDS BALTO. MD 21218</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF  
(b) **Lung Carcinoma**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <b>January 20, 1984</b> to <b>March 18, 1984</b> , that (X) (we) lost saw the deceased alive on <b>March 18, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.			
22b. SIGNATURE <i>Elizabeth Rogers</i>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/21/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELIZABETH ROGERS, MD.</b>		22e. ADDRESS <b>3900 Loch Raven Blvd. Balto. Md 21218</b>	

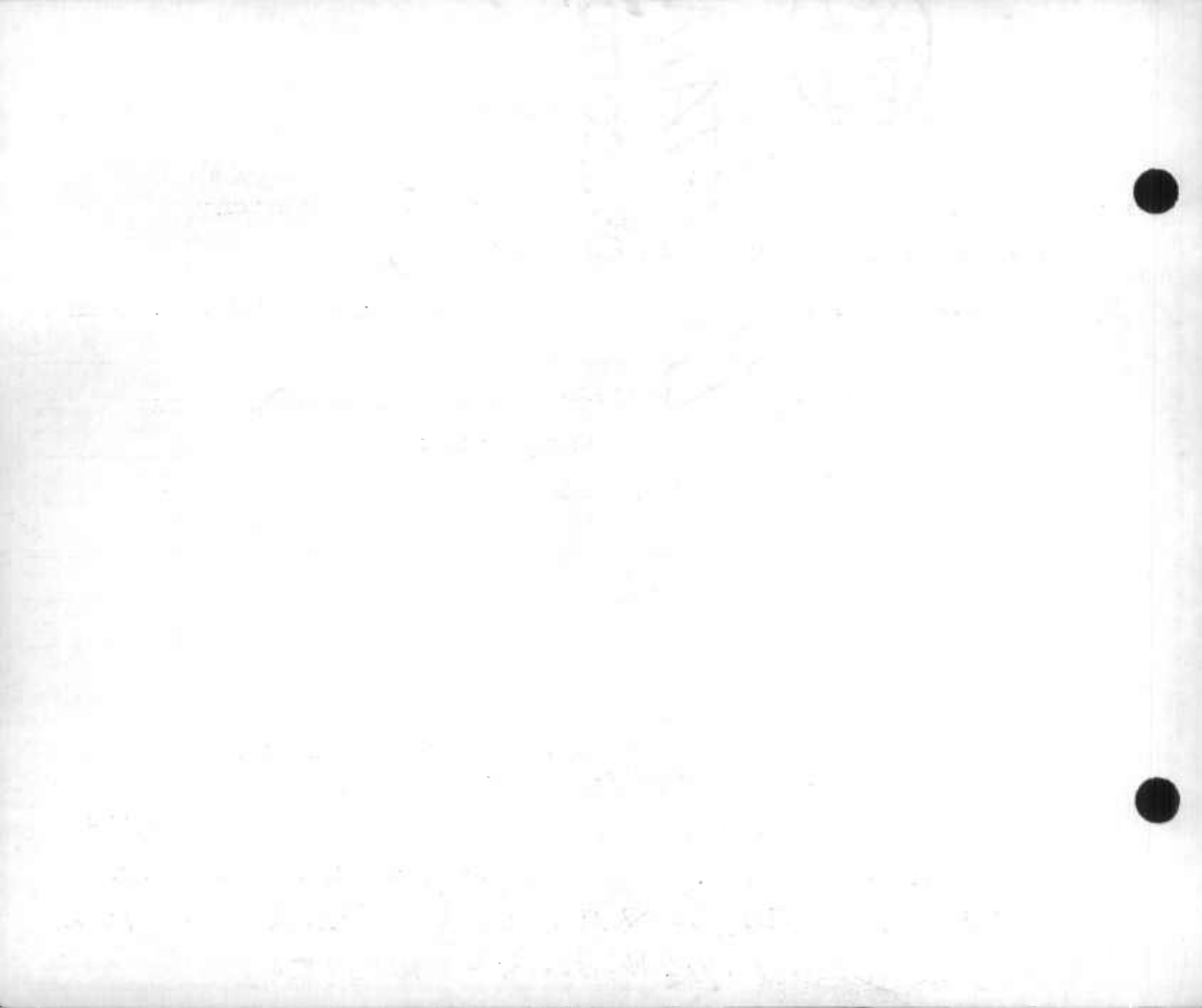
23a. BURIAL, CREMATION, REMOVAL	23b. DATE <b>3/27/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Nat. Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <i>Lowell W. North</i>		25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b>	25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Marion G. Gillis						3/2/84 19						M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Female		Black		10 07 1900		83 YRS.				3/2/84 19		6:27 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia				U. S. A.								Baltimore City MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				827 N. Arlington Ave.				Counter Lady				Md. Casulty			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS							
Henry				Lucy				827 N. Arlington Ave.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No.				215-16-6546				Archie Deane				2313 Bryant Ave. Baltimore, Maryland 21217			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Thomas D. Smith, M.D.				Dep. Chief				3/3/84							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas D. Smith, M.D.				111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				3/6/1984		Baltimore National Cem.				Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
Nutter & Sons Funeral Home Inc.						MAR 6 1984						John Davidson-Randell			
Baltimore, Maryland 21216 -2501 Gwynns Falls Pkwy.															

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Female Black 10 07 1900 21

U. S. A. Virginia

Counter Lady M. G. G. G. G.

827 N. Arlington Ave.

W. F. 407 Baltimore, Md. 21211

Baltimore

Henry M.

Lucy

Deane

Henry

2313 Myrtle Ave.

Baltimore, Maryland 21217

212-16-8346

No.

Maryland

Baltimore National Cem. Baltimore

Inter. & Sons Funeral Home Inc.

Baltimore, Maryland 21216-2501 Cypress Hills Bkwy.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06899

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Addie W. Glasgow</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 21 1984</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 22 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2934 Winchester Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>General Service Adm.</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2934 Winchester St. Baltimore, Md. 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Glasgow</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Henry</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>213-20-5915</b>		17. INFORMANT <b>Dorothy Glasgow</b> ADDRESS <b>2934 Winchester St. Baltimore, Maryland 21216</b>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

**CARDIORESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) **HEPATIC/PULMONARY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **SMALL CELL CA LUNG**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Thomas D. Brown</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>3/22/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas D. Brown</b>	22e. ADDRESS <b>Johns Hopkins Oncology CTR 600 N Wolfe St Baltimore, MD 21205</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/27/1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
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24. FUNERAL DIRECTOR NAME <b>Nutter &amp; Sons Funeral Home Inc.</b> ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1984</b>	25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Female	Black	4	22	1931	62	Baltimore City
Henry	U. S. A.					
Baltimore	223 Winchester Street	Supervisor				General Service Adm.
Henry	Baltimore	X				223 Winchester St. Baltimore, Md. 21210
Charles	Glasgow	Henry				223 Winchester St. Baltimore, Maryland 21210
No.	213-20-2415	Dorothy				

2501 G. Anne Falls Hwy. Baltimore, Md. 21216  
 Master & Sons General Home Inc.  
 3/27/1982 St. Anthony's Rectory Baltimore, Maryland  
 Henry

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>SYLVESTER F. GOEPFERT</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>3-23-84</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 31 1902 81</b> YRS.	6. AGE (IN YEARS) LAST BIRTHDAY <b>81</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>3-23-84</b>		2d. HOUR <b>3AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>262 S. Bouldin</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Exxon</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21224</b> <b>262 S. Bouldin St., Balto. 21224</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Joseph Goepfert</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary - Samek</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214 03 6398</b>		17. INFORMANT ADDRESS <b>Mary E. Selway 3602 E. Fayette St. 21224</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>3-23-84</b>					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 26 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler, Inc.</b>		ADDRESS <b>700 S. Conkling St. 21224</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the 72 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN G GOHLINGHORST</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>14</b> YEAR <b>84</b>		2b. HOUR <b>8:31</b> P.M.	
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>29</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COOK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>21204</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1645 YAKONA RD 21204</b>	
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>George</b> LAST <b>Gohlinghorst</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Jenny</b> MIDDLE <b>M.</b> LAST <b>Paham</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW II 217-09-884</b>		17. INFORMANT ADDRESS <b>Catherine M. Gohlinghorst 21204 1645 Yakona Rd</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST - VENTRICULAR FIBRILLATION</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 20 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <b>(b) RESPIRATORY FAILURE</b> <b>10 days</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>51 minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>DIABETES MELLITUS</b>						
19a. DATE OF OPERATION <b>3/14</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>3/13</b>		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>84</b> , to <b>3/14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Gregory P. Harris</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/14/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY P. HARRIS</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL 21205</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 17, '84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN <b>Baltimore Co., MD</b> COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>		ADDRESS <b>8521 Loch Raven Blvd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John A. Borden - Handell</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IDA SHIRLEY GOLDBERG</b>						MONTH DAY YEAR <b>3 5 84</b>			
2. SEX <b>F FEMALE</b>						2b. HOUR <b>9:45 PM</b>			
4. RACE <b>CAUCASIAN</b>						6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.			
5. DATE OF BIRTH MONTH DAY YEAR <b>08 09 08</b>						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA MARYLAND</b>						9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>			
7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MANAGER</b>			
10. CITY OR TOWN OF DEATH <b>BAL. CITY</b>						12b. KIND OF BUSINESS OR INDUSTRY <b>IMPORT/EXPORT</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>						13a. STREET ADDRESS / ZIP CODE <b>APT. T-2 21208</b>			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MD.</b>						13b. INSIDE CITY LIMITS? <b>NO XX</b>			
12b. COUNTY <b>BALTO.</b>						13c. STREET ADDRESS / ZIP CODE <b>7200 CHALKSTONE DR. 21208</b>			
13. CITY OR TOWN <b>BALTIMORE</b>						14. FATHER'S NAME FIRST MIDDLE LAST <b>RUBEN ZIMAN</b>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HILDA SMULENITZ</b>						16. SOCIAL SECURITY NO. <b>213-01-2861</b>			
17. INFORMANT <b>SAMUEL GOLDBERG HUSBAND</b>						18. ADDRESS <b>APT. T-2 #21208 7200 CHALKSTONE DR.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RECURRENT MASSIVE MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hx of V. Tach. MI.</b>									
19a. DATE OF OPERATION <b>3-3-84</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MI</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>3-3-84</b> , to <b>3-5-84</b> , that (a) (we) lost saw the deceased alive on <b>3-5-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Shobha Reddy MD</b>						22c. DATE SIGNED <b>3.5.84</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHOBHA REDDY</b>	
22e. ADDRESS <b>SINAI HOSP.</b>						23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			
23b. DATE <b>MAR. 7, 1984</b>						23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>			
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>						24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1984</b>						25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST MIDDLE LAST Anna M Gomolka				MONTH DAY YEAR March 18, 1984				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR Sept 22, 1907		76 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		3108 Clearview Ave				Secretary			
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE			
Maryland				Baltimore		3108 Clearview Ave 21234			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST George Gomolka				FIRST MIDDLE LAST Mary Szymanski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				212-09-0277		Mr Henry Gomolka Same As 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>89</u> to <u>1/21</u> 19 <u>89</u> , that (I) (we) lost saw the deceased <u>on</u> <u>1/21</u> 19 <u>89</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>A.P. Davis</u>				MD				3/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
<u>A.P. Davis</u>				<u>M.D.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				3/22/84		Holy Rosary		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Buck Inc. Baltimore, Maryland				MAR 20 1984		<u>John Davidson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be included by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, medical examination must be completed at once.


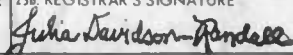
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES A. GOODE JR.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>3 1 19 84</b>		2b. HOUR <b>9:04 a.m.</b>	
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 31 10 74 YRS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>IF UNDER 24 HRS. HOURS MIN.</b>		2c. DATE PRONOUNCED DEAD <b>3 1 19 84</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21219 2716 Sparrows Point Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Goode, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Davis</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					
16a. SOCIAL SECURITY NO. <b>213-07-2571</b>				17. INFORMANT ADDRESS <b>Catherine F. Goode 2716 Sparrows Point Rd.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4029 Hypertensive &amp; arteriosclerotic cardiovascular disease</b> IMMEDIATE CAUSE (a) <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>3-1-84</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/6/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem. Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>						ADDRESS <b>1101 E North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1984</b>		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06905

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT L. GOODMAN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 23, 1984			2b. HOUR 11:42 A.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 29, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6033 BERKELEY AVE. 21209				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY CERTIFIED PUBLIC ADJUSTER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6033 BERKELEY AVE. 21209	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY GOODMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH MEYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) US NAVY-WWII 219-18-9227		17. INFORMANT ADDRESS MRS. ELIZABETH GOODMAN 6033 BERKELEY AVE. 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4180 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 1			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1984</u> , to <u>MAR 22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MAR 22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.									
22b. SIGNATURE <u>Seymour Rubin</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SEYMOUR RUBIN						22e. ADDRESS 7111 PARK HEIGHTS AVE.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/25/84		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM PARK		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215						25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE <u>J. Davidson Handell</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY THOMAS GORENFLO			2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1984			2b. HOUR 12:00p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 23 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1751 Burnham Road 21222		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk					
14. FATHER'S NAME FIRST MIDDLE LAST Henry T. Gorenflo				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose L. Evans					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 239 03 8433		17. INFORMANT Marsha Gorenflo				ADDRESS Same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MN6 Cancer Metastatic to Brain</u> (c) <u>CHF and Acute Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Anemia, Azotemia, HTN, ADDM, AND IMMOBILITY 2° TO ARTHRITIS</u>							
19a. DATE OF OPERATION - N/A -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - N/A -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) - N/A -			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>Feb. 13</u> , 19 <u>84</u> , to <u>March 6</u> , 19 <u>84</u> , that (X) (we) last saw the deceased alive on <u>March 6</u> , 19 <u>84</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Constantine Gean</u> MD DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3-6-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Constantine Gean</u> MD				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/12/1984		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR MAR 9 1984			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		3- DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6 9 0 7	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH	
Alexander Gorum				2b. HOUR	
3. SEX				2c. DATE PRONOUNCED DEAD	
Male				3 24 19 84	
4. RACE				2d. HOUR	
Black				4:56	
5. DATE OF BIRTH				7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
8 4 59				Virginia	
6. AGE (IN YEARS LAST BIRTHDAY)				7b. CITIZEN OF WHAT COUNTRY?	
24 YRS.				U.S.A.	
IF UNDER 1 YR.				8. MARRIED	
IF UNDER 24 HRS.				NEVER MARRIED	
MONTHS				WIDOWED	
DAYS				DIVORCED	
HOURS				9. BALTIMORE CITY OR COUNTY OF DEATH	
MIN.				Baltimore City	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Baltimore				Johns Hopkins Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE				13b. COUNTY	
Maryland				Baltimore	
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS				13f. STREET ADDRESS	
1035 Orleans Street				21202	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST				FIRST MIDDLE LAST	
Mary M. Gorman				Mary M. Gorman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.	
YES				224-88-8050	
17. INFORMANT				17. INFORMANT	
Mary M. Gorman				Mary M. Gorman	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Stab wound of chest					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION				20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY	
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				3:30xx 3 24 1984	
21d. INJURY OCCURRED				Subject stabbed	
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>					
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION	
home				STREET CITY OR TOWN COUNTY STATE	
1035 Orlean St.				Baltimore Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
TITLE (SPECIFY)					
Assistant					
DATE SIGNED 3/24/84					
EXAMINER'S NAME (TYPE OR PRINT)					
Dennis F. Smyth, M.D.					
ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL (SPECIFY)					
BURIAL					
23b. DATE					
3/28/84					
23c. NAME OF CEMETERY OR CREMATORY					
Mount Zion Cemetery					
23d. LOCATION					
Lansdowne, Md.					
24. FUNERAL DIRECTOR					
NAME ADDRESS					
Wm C March F/H Inc. 1101 E North Avenue					
25a. DATE REC'D. BY REGISTRAR					
MAR 28 1984					
25b. REGISTRAR'S SIGNATURE					
Julia Davidson-Randall					

RECEIVED

10/10/10



10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>NATHAN J. GRADDICK, SR.</b>						2a. DATE OF DEATH MONTH <b>3</b> DAY <b>27</b> YEAR <b>84</b>		2b. HOUR <b>M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>2</b> YEAR <b>1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ship Yard Work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Edgemere</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2601 Edgemere Avenue 21219</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Monding</b> LAST <b>Graddick</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Harriet</b> MIDDLE <b></b> LAST <b>Watts</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I</b>		17. INFORMANT <b>Nathan J. Graddick, Jr.</b>		ADDRESS <b>Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>20 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>Chronic Obstructive Pulmonary Disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dorothy Ann Snow, M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/27/84</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/30/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Kia Davidson-Randall</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST Bernard MIDDLE C. LAST Grady <i>Bernard C. Grady</i>		2a. DATE OF DEATH MONTH DAY YEAR 3 5 84 2b. HOUR 11:40 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 16 1909	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Shipyard	13b. STREET ADDRESS 810 South Ponca Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Ira Grady	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Novel Bell	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 183-05-4394	17. INFORMANT Elizabeth C. Grady	ADDRESS 810 S. Ponca Street Balto. MD 21224	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  
*Chronic Degeneration Emphysema Abdominal Aortic Aneurysm*

19a. DATE OF OPERATION <i>3/5</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/3</i> 19 <i>84</i> , to <i>3/5</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>3/5</i> 19 <i>84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Robert A. Weisgrau</i>		DEGREE MD	22c. DATE SIGNED <i>3/6/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. WEISGRAU M.D.		22e. ADDRESS BALTIMORE CITY HOSPITALS, BALTIMORE MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/9/84	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222		25. DATE REC'D. BY REGISTRAR MAR 7 1984	26. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				06910			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>PEGGY NMI GRAHAM</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/17/84</b>		2b. HOUR <b>10<sup>05</sup> AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 34</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1005 Edmondson Ave 21217</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Washington</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lummie Miller</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>22-46-2957</b>		17. INFORMANT ADDRESS <b>Leo Graham 1005 Edmondson Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY DEPRESSION / APNEA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>END STAGE DIABETES MELLITUS / ? SEPSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>RENAL FAILURE, PERIPHERAL VASCULAR DISEASE, DIABETIC ENTEROPATHY</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/1984</b> to <b>3/17/1984</b> , that (I) (we) most saw the deceased alive on <b>3/17/1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Henry M Richards MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-17-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HENRY M RICHARDS MD</b>		22e. ADDRESS <b>Univ of Md. Hosp. 225 GREENE ST. BALT. MD 21209</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/23/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										6911									
1. DECEASED NAME (TYPE OR PRINT) <b>PHILLIP C. GRAHAM</b>										2a. DATE KNOWN OF DEATH <b>3-2-84</b> 19 <b>8:15AM</b>									
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH <b>JAN. 16, 1962</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>22</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>3-2-84</b> 19 <b>8:15AM</b>		2d. HOUR							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5118 Cordelia Avenue</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5118 CORDELIA AVE.</b>											
14. FATHER'S NAME FIRST <b>ROY</b> MIDDLE <b>DOUGLASS</b> LAST <b>COLVIN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>OPHELIA</b> MIDDLE <b>HARRIS</b> LAST				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO. <b>218-84-6874</b>		17. INFORMANT ADDRESS <b>OPHELIA HARRIS 5118 CORDELIA AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging</b> <b>9530</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3-?-84</b> 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject found hanging</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>basement</b>				21f. LOCATION STREET <b>5118 Cordelia Ave.</b> CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Maryland</b> STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Margarita A. Korell</b> M.D. <b>Assistant</b> MEDICAL EXAMINER										TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>										ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>3/6/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. AUBURN CEM.</b>				23d. LOCATION CITY OR TOWN <b>BALTO., MD.</b> COUNTY STATE									
24. FUNERAL DIRECTOR <b>LEROY O. DYETT 4600 LIPPERTY HGTS. AVE.</b>										25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1984</b> REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>									



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Items 18-22a 5/22/84 mth F#591

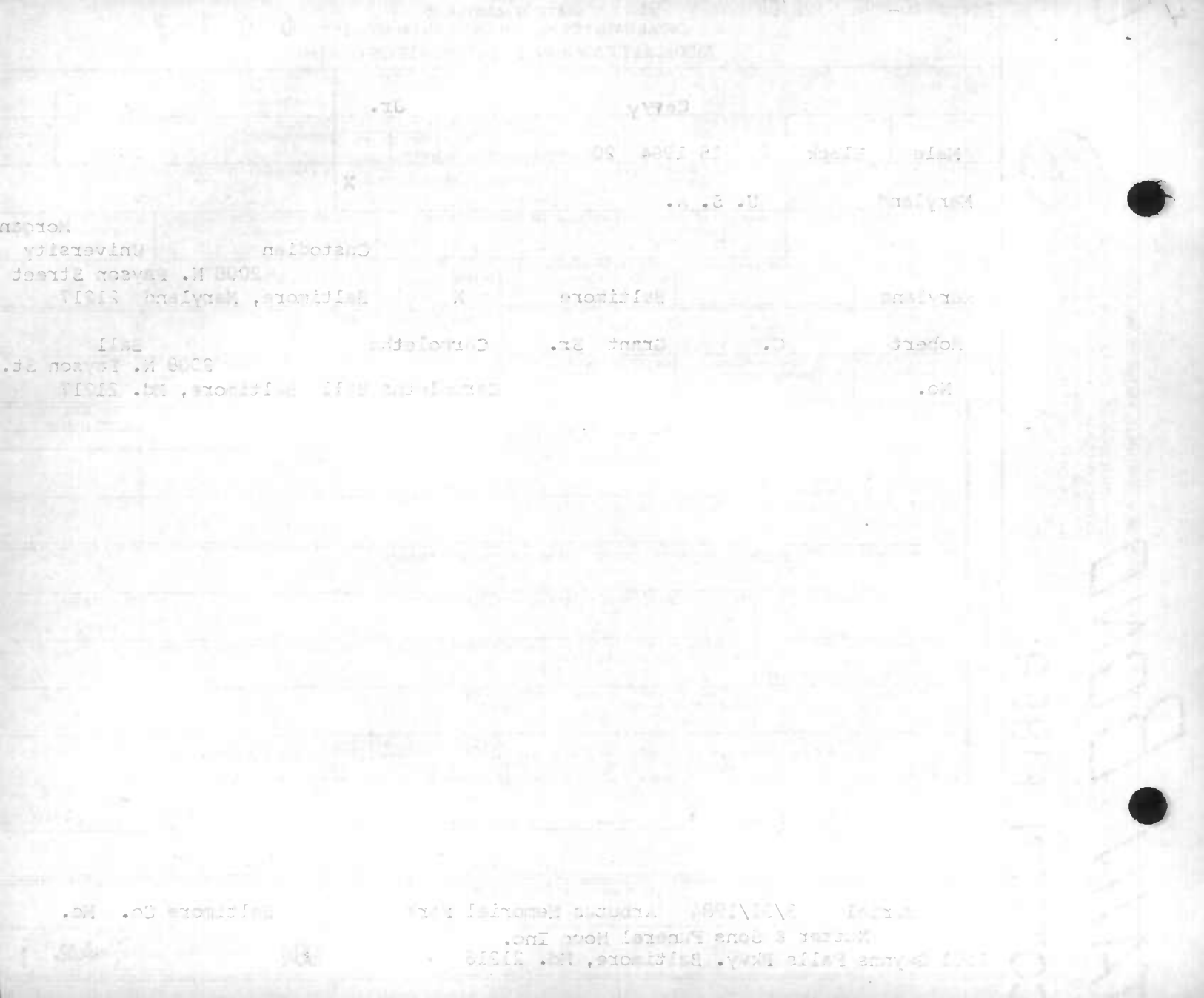
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6913

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH ESTIMATED				MONTH DAY YEAR				2b. HOUR							
Robert				Carey				Grant				Jr.				3 26 1984		M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR							
Male		Black		2 15 1964		20 YRS.						3 26 1984		P M		2:35							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				U. S. A.								Baltimore City, MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore				Provident Hospital				Custodian				University											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								13d. INSIDE CITY LIMITS?								13e. STREET ADDRESS							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2008 N. Payson Street Baltimore, Maryland 21217							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																			
Robert C. Grant Sr.				Carmoletha Ball																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS															
No.								Carmoletha Ball Baltimore, Md. 21217															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Seizure disorder</u>																							
7803																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																							
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE								TITLE (SPECIFY)								DATE SIGNED							
Ann M. Dixon, M.D.								Assistant								3/27/84							
EXAMINER'S NAME (TYPE OR PRINT)								ADDRESS															
Ann M. Dixon, M.D.								111 Penn St. Balto., MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				3/31/1984				Arbutus Memorial Park				Baltimore Co. Md.											
24. FUNERAL DIRECTOR NAME ADDRESS												25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE											
Nutter & Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216												MAR 30 1984 John Davidson-Randall											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06914

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Baby Boy Larry D. Gray Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/22/84</i>			2b. HOUR <i>8:00 AM</i>			
3. SEX <i>MALE</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 22 84</i>		6. AGE IN YEARS (LAST BIRTHDAY) <i>0</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>1 30</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.) <i>BABY</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Baltimore</i>									
14. FATHER'S NAME FIRST MIDDLE LAST <i>LARRY DARNELL GRAY SR.</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNETTE BOND</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>Mrs ANNETTE B. GRAY 3442 PENHURST AVE 21215</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART 1. DEATH WAS CAUSED BY:

*7651* IMMEDIATE CAUSE (a) *Prematurity*  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3/22/84 3/22 84</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/22/84</i> 19 to <i>3/22</i> 19, that (I) (we) last saw the deceased alive on <i>3/22/84</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Neal K. Rotin</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/22/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NEAL K. ROTIN</i>				22e. ADDRESS <i>Sinai Hosp of Baltimore</i>			

23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>3-24-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST LUKAS CEM</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>REISTERSTOWN BALTO CO MD</i>	
24. FUNERAL DIRECTOR NAME <i>JOSEPH L. RUSSELL 2722 W. NORTH AVE</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAR 27 1984 Julia Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

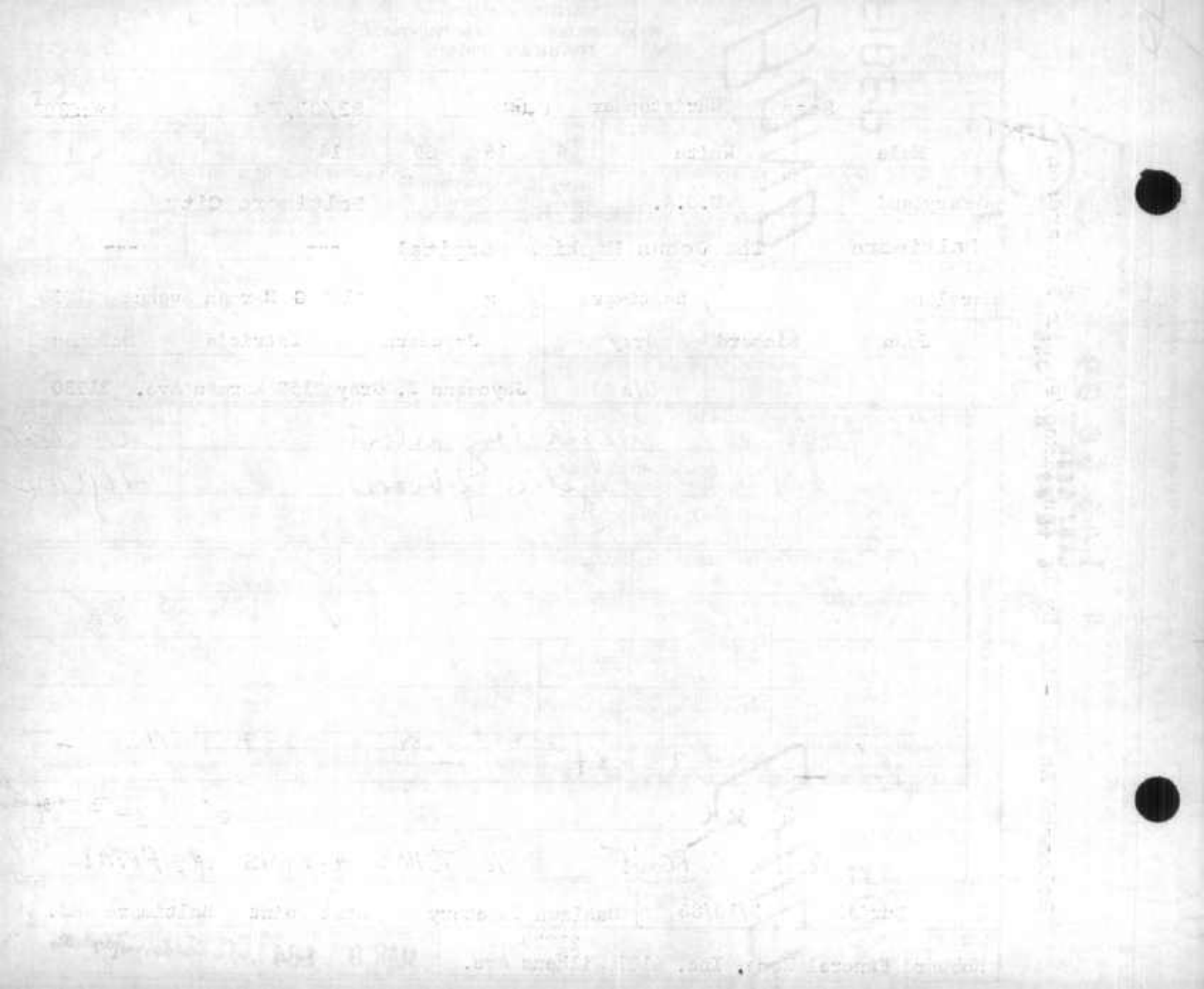
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, the funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to the burial. Page 2 should be filed with the funeral director. Page 4 should be filed with the funeral director. Page 5 should be filed with the funeral director. Page 6 should be filed with the funeral director. Page 7 should be filed with the funeral director. Page 8 should be filed with the funeral director. Page 9 should be filed with the funeral director. Page 10 should be filed with the funeral director. Page 11 should be filed with the funeral director. Page 12 should be filed with the funeral director. Page 13 should be filed with the funeral director. Page 14 should be filed with the funeral director. Page 15 should be filed with the funeral director. Page 16 should be filed with the funeral director. Page 17 should be filed with the funeral director. Page 18 should be filed with the funeral director. Page 19 should be filed with the funeral director. Page 20 should be filed with the funeral director. Page 21 should be filed with the funeral director. Page 22 should be filed with the funeral director. Page 23 should be filed with the funeral director. Page 24 should be filed with the funeral director. Page 25 should be filed with the funeral director. Page 26 should be filed with the funeral director. Page 27 should be filed with the funeral director. Page 28 should be filed with the funeral director. Page 29 should be filed with the funeral director. Page 30 should be filed with the funeral director. Page 31 should be filed with the funeral director. Page 32 should be filed with the funeral director. Page 33 should be filed with the funeral director. Page 34 should be filed with the funeral director. Page 35 should be filed with the funeral director. Page 36 should be filed with the funeral director. Page 37 should be filed with the funeral director. Page 38 should be filed with the funeral director. Page 39 should be filed with the funeral director. Page 40 should be filed with the funeral director. Page 41 should be filed with the funeral director. Page 42 should be filed with the funeral director. Page 43 should be filed with the funeral director. Page 44 should be filed with the funeral director. Page 45 should be filed with the funeral director. Page 46 should be filed with the funeral director. Page 47 should be filed with the funeral director. Page 48 should be filed with the funeral director. Page 49 should be filed with the funeral director. Page 50 should be filed with the funeral director. Page 51 should be filed with the funeral director. Page 52 should be filed with the funeral director. Page 53 should be filed with the funeral director. Page 54 should be filed with the funeral director. Page 55 should be filed with the funeral director. Page 56 should be filed with the funeral director. Page 57 should be filed with the funeral director. Page 58 should be filed with the funeral director. Page 59 should be filed with the funeral director. Page 60 should be filed with the funeral director. Page 61 should be filed with the funeral director. Page 62 should be filed with the funeral director. Page 63 should be filed with the funeral director. Page 64 should be filed with the funeral director. Page 65 should be filed with the funeral director. Page 66 should be filed with the funeral director. Page 67 should be filed with the funeral director. Page 68 should be filed with the funeral director. Page 69 should be filed with the funeral director. Page 70 should be filed with the funeral director. Page 71 should be filed with the funeral director. Page 72 should be filed with the funeral director. Page 73 should be filed with the funeral director. Page 74 should be filed with the funeral director. Page 75 should be filed with the funeral director. Page 76 should be filed with the funeral director. Page 77 should be filed with the funeral director. Page 78 should be filed with the funeral director. Page 79 should be filed with the funeral director. Page 80 should be filed with the funeral director. Page 81 should be filed with the funeral director. Page 82 should be filed with the funeral director. Page 83 should be filed with the funeral director. Page 84 should be filed with the funeral director. Page 85 should be filed with the funeral director. Page 86 should be filed with the funeral director. Page 87 should be filed with the funeral director. Page 88 should be filed with the funeral director. Page 89 should be filed with the funeral director. Page 90 should be filed with the funeral director. Page 91 should be filed with the funeral director. Page 92 should be filed with the funeral director. Page 93 should be filed with the funeral director. Page 94 should be filed with the funeral director. Page 95 should be filed with the funeral director. Page 96 should be filed with the funeral director. Page 97 should be filed with the funeral director. Page 98 should be filed with the funeral director. Page 99 should be filed with the funeral director. Page 100 should be filed with the funeral director.

Released As Noted By Dr. J. B. Richardson

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06915

1. DECEASED NAME (TYPE OR PRINT) <b>Sean Christopher Gray</b>		20. DATE OF DEATH MONTH DAY YEAR <b>03/07/84</b>		2b. HOUR <b>8:30 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 16 69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>14</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Richard Gray</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Joyceann Patricia McDonough</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/a</b>		17. INFORMANT ADDRESS <b>Joyceann P. Gray 2152 Harman Avenue 21230</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2770</b> <i>respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cystic fibrosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>14 years</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3-7</b> , 19 <b>84</b> , to <b>3-7</b> , 19 <b>84</b> , that (1) <del>last</del> saw the deceased alive on <b>MARCH 7</b> , 19 <b>84</b> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>did</del> (did not) view the body after death.					
22b. SIGNATURE <i>Peter C. Rowe</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-7-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER C. ROWE</b>		22e. ADDRESS <b>% JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/10/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>East Point Baltimore Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1984</b>	
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or boxed B shows any injury, or other traumatic event, the medical examiner must be used to find out cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR <b>LUCREZIA C. GRECO</b>					
1. DECEASED NAME (TYPE OR PRINT) <b>Lucrezia C. Greco</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>28</b> YEAR <b>84</b>		2b. HOUR <b>11 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>25</b> YEAR <b>38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.	IF UNDER 1 YEAR MONTHS <b>+</b> DAYS <b>+</b> HOURS <b>+</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Sicily</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> (MD.)	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Maryland Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Md</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSURANCE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Cosimo</b> MIDDLE <b>Battaglia</b> LAST <b>Battaglia</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Maria</b> MIDDLE <b>Elardo</b> LAST <b>Elardo</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)		17. SOCIAL SECURITY NO. <b>216-40-1752</b>		17. INFORMANT <b>Vincent Greco</b> ADDRESS <b>1107 Kent Ave Balt., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>11629</b> IMMEDIATE CAUSE (a) <b>Severe Respiratory Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Benign Prostatic Hyperplasia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8 months</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>March 26, 19 84</b> to <b>March 28, 19 84</b> , that (we) last saw the deceased alive on <b>March 28, 19 84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE <b>Dennis J. Gangulio</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/28/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dennis J. Gangulio</b>		22e. ADDRESS <b>Univ Md Cancer Center, Univ of Md Hosp, Balt.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/31/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>	
23d. LOCATION CITY OR TOWN <b>Timonium</b>		COUNTY <b>MD.</b>		STATE	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke</b>		ADDRESS <b>Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendall</b>					



INDEX

*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06917

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward F Green Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 21, 1984</b>		2b. HOUR <b>2:26AM</b>
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 1, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Steam Fitter</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5638 Woodmont Ave 21239</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward F Green Sr</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-09-7230</b>		17. INFORMANT ADDRESS <b>Mrs Dorothea A Green Same As 13e</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute MYOCARDIAL INFARCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **CHRONIC OBSTRUCTIVE LUNG DISEASE**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 28</b> , 19 <b>84</b> , to <b>MAR 21</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>FEB. 15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Dr. Alexander, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/21/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marcio M Menendez M.D.</b>		22e. ADDRESS <b>5820 York Rd Baltimore, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>3/22/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 22 1984</b>	
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REPORTEDLY INFECTED  
WITH VARIOUS DISEASES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

APR 24 1954  
MAR 21 1954

42114

✓  
W. H. HARRIS, M.D.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06718

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAMIE GREEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 17, 1984</b>			2b. HOUR <b>6:37A</b> M					
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 15 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>939 E. Chase St. 21202</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Liby Brooks</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl Wiggins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>238-40-6073</b>			17. INFORMANT ADDRESS <b>Augustus Green 939 E. Chase St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECURRENT CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY DISTRESS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROBABLE LUNG METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1629</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>			
								<b>12hrs</b>			
								<b>1 (Colon Cancer x'd May 1983)</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <b>COLON CANCER; DIABETES MELLITUS</b>											
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 17, 1984</b> , to <b>MARCH 17, 1984</b> , that (I) (we) last saw the deceased alive on <b>MARCH 17, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas Adams Corson M.D.</b>						DEGREE <b>—</b>		22c. DATE SIGNED <b>March 17, 1984</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS ADAMS CORSON, M.D.</b>						22e. ADDRESS <b>601 N. BROADWAY 21205</b> <b>THE JOHNS HOPKINS HOSPITAL, N. WOLFEST, BALTIMORE, MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/21/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Aye,</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

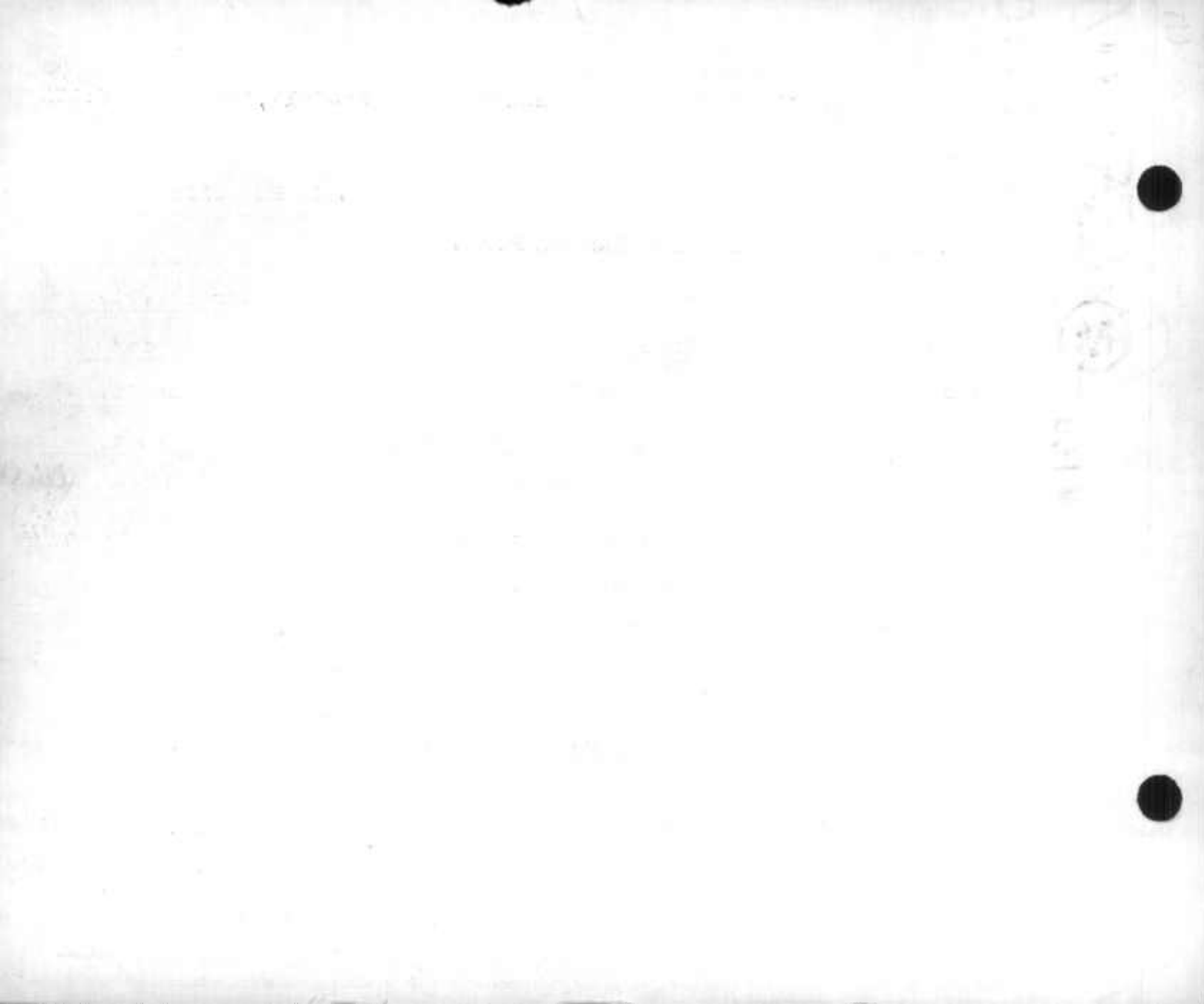
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove the accompanying page and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked for item 18, show any injury, or other traumatic event, and the medical examiner's findings.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06919

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
SANCO GREEN					3/24/84					3 A M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.		
M	B		6 20 29		54 YRS.		MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
S. Carolina		U.S.A.				Balt city MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balt		University of Md Hosp.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		836 Vine St. Balt 21223			
Md		C		Balt							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST	
RUBIN		GREEN				A OELINE				REGAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		726-16-4381		Ann Green		1820 W. Lombard Street					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) POSSIBLE Cerebral-Vascular-ACCIDENT

24 h

DUE TO, OR AS A CONSEQUENCE OF

(c) POSSIBLE MYOCARDIAL INFARCTION

24 h

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

PROBABLE Sepsis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/23, 1984, to 3/24, 1984, that (I) (we) last saw the deceased alive on 3/24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Jay R Schachner MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Jay R. Schachner				University of Md Hospital, Med.			

23a. BURIAL, CREMATION, REMOVAL (SEE CODE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/28/84		Cedar Hill Cem.		Anne Arundel Co, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H Inc. 1101 E North Avenue				MAR 27 1984		Julia Davidson-Randell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										6 7 2 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHRISTOPHER LAMONT GREENE										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 11 19 84		2b. HOUR M 3:18 AM	
3. SEX MALE		4. RACE COL		5. DATE OF BIRTH MONTH DAY YEAR FEB 5, 1984		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 6		IF UNDER 1 YR. HOURS MIN. 16		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 11 19 84		2d. HOUR M 3:18 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BABY				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4714 WILVERN AVE 21215			
14. FATHER'S NAME FIRST MIDDLE LAST CHRIS E. GREENE										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRENDA GREENE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS 21215 MRS BRENDA GREENE 4714 WILVERN AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-11-84					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-14-84				23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.				23d. LOCATION CITY OR TOWN COUNTY Lansdown Md.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2222 W. North Ave.				25a. DATE REC'D. BY REGISTRAR MAR 19 1984				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322 UCBAW/DAT

RECEIVED

NOV 10 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DAISY MAE GREENE</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>84</b>			2b. HOUR M			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>JULY</b> DAY <b>14</b> YEAR <b>1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAR.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4410 SPRINGDALE AVE. 21207</b>	
14. FATHER'S NAME FIRST <b>THOMAS</b> MIDDLE <b>STREET</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>EBBIE</b> MIDDLE <b>STREET</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>TIMOTHY GREENE 4410 SPRINGDALE AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Probable Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1710 Myocardial Infarction, Congestive Heart Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>2/17</b> , 19 <b>86</b> , to <b>3/29</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb 16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Rifat Aboumy</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rifat Aboumy</b>					22e. ADDRESS <b>2 HAMILL RD. BALTO, MD 21210</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		23d. LOCATION CITY OR TOWN <b>BALTO., MD.</b> COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 5 - 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
MILTON		GREENEBAUM		MARCH 28, 1984		6:58P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE	WHITE	DECEMBER 23, 1896		87		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SINAI HOSPITAL		EXECUTIVE		L. GREIF & SONS	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND			BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		(21215) 6317 PARK HEIGHTS AVE., APT. 101	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
SOLOMON N		REBECCA		YES		214-01-8210	
17. INFORMANT		ADDRESS		17. INFORMANT			
STANLEY GREENEBAUM		3515 AUTUMN DRIVE 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest assoc. w/ arrhythmia</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>due to A's &amp; Hypert Ht Dis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u> <u>2 days</u> <u>30 days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 19 83</u> to <u>Nov 18, 83</u> , that (I) (we) lost saw the deceased alive on <u>Nov 18, 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Donald Cohen MD</u>		22c. DATE SIGNED <u>3/29/84</u>		22d. ADDRESS 6702 PARK HEIGHTS AVE.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/30/84		ARLINGTON CEMETERY		BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		APR 2 1984		<u>John Davidson-Rendell</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LULA M. GREENWALT</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>17</b> YEAR <b>84</b>		2b. HOUR <b>6:50 P</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>03</b> YEAR <b>12</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food Service</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Race Track</b>		
13a. STATE <b>W. Virginia</b>	13b. COUNTY <b>Kerneysville</b>	13c. CITY OR TOWN <b>Kerneysville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Shamlin</b> MIDDLE <b></b> LAST <b></b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>M.</b> LAST <b>Nora Ott</b>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. <b>235-70-1595</b>		17. INFORMANT ADDRESS <b>Edith Densmore P.O. Box 278 W. Va. 25430</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Obstructive Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia (R) upper lobe</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>ASCD; Supraventricular Tachycardia &amp; COPD</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/29</b> 19 <b>84</b> to <b>3/17</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Beltran</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOAN A. BELTRAN</b>		22e. ADDRESS <b>1940 W. BALTIMORE ST, BALD, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>March 20, 84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY <b>Charlestown Jefferson W. Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REV. OLIVER J. GREER SR.			2a. DATE OF DEATH MONTH DAY YEAR MARCH 14, 1984			2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 23 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3003 CHERRYLAND ROAD APT. J				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Greer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Hollingsworth		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 213-09-9714		17. INFORMANT ADDRESS Apt. J. Carolyn Greer 3003 Cherryland Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert H. Levitt MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert H. Levitt MD		22e. ADDRESS University Hsp. fac					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/20/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06925

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theresa Louise Greif			2a. DATE OF DEATH MONTH DAY YEAR 3 29 84			2b. HOUR 9 40 P.M.				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 30 19		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS 10 40		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. END OF BUSINESS OR INDUSTRY N/A		
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 21225 3741 St. Victor Street.			
14. FATHER'S NAME FIRST MIDDLE LAST Tony T Devincent			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Marie Lombardi			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown N/A			16b. SOCIAL SECURITY NO. 218-09-9564	
17. INFORMANT Donna Dun			ADDRESS 7668 Pine Haven Dr 21122							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

11629

IMMEDIATE CAUSE (a) Respiratory compromise secondary to End-stage Acute pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) Squamous cell carcinoma of Lung with

DUE TO, OR AS A CONSEQUENCE OF Secondary Liver mets + brain mets

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/24/84, 19 84, to 3/29/84, 19 84, that (I) (we) last saw the deceased alive on 3/29/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. Freeman-Pendergraft				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. FREEMAN-PENDERGRAFT				22e. ADDRESS 501 Baltimore General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Men. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md.	
24. FUNERAL DIRECTOR NAME McCurly F.H. Mountain & Tick Neck Rds. Pasadena, Md.				25a. DATE REC'D. BY REGISTRAR APR 3 1984		25b. REGISTRAR'S SIGNATURE Freeman-Pendergraft	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 4 per phone  
3/14/84 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06926

RAR

REG. NO.

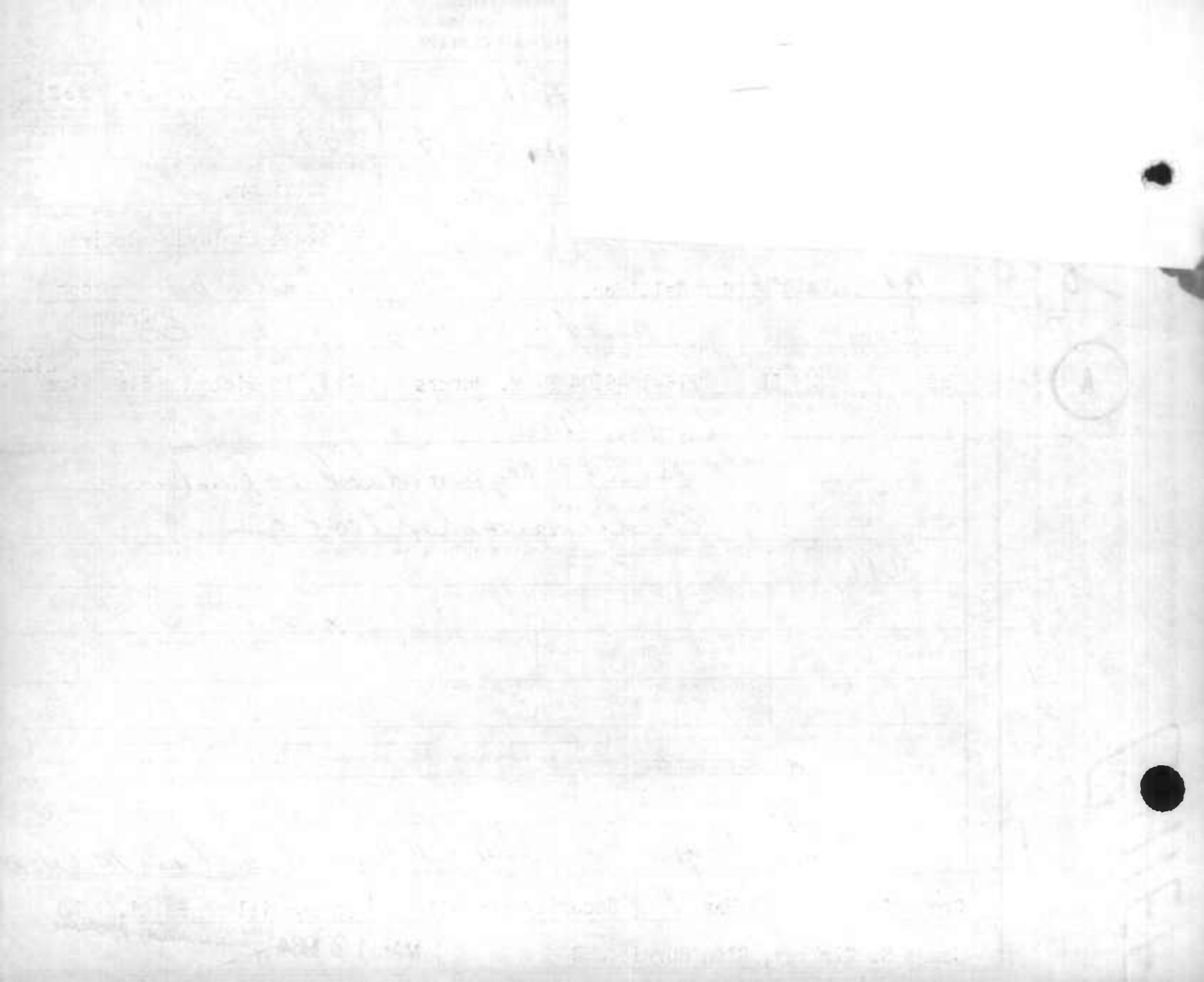
1. FULL NAME (PRINT) <b>Conrad N Griebel</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3-11-84</b>		2b. HOUR <b>307 M</b>	
3. SEX <b>M</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-13-17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> <b>Sept</b>	
9. CITY OR TOWN OF DEATH <b>Baltimore</b>		10. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>md Baltimore</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MD State Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>md</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE <b>George Griebel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Mary I Brown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 216-10-8204</b>		17. INFORMANT ADDRESS <b>Baltimore 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiomegaly (1000 gms)</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>COPD</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. Pagan</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-11-84</b>	
22d. PHYSICIAN'S NAME (TYPE PRINT) <b>Edwin Pagan</b>		22e. ADDRESS <b>3001 South House St Baltimore MD 21220</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>13 Mar 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balti MD</b>		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <b>MAR 12 1984</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>James S. Kirkley, Glen Burnie, MD</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained with 24 hours retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical certificate must be signed by a

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06921

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
CROWDER		MARCH 7, 1984		6:08A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. UNDER 1 YEAR	
Male	Black	Dec. 10-1910	73 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
N.C.	U.S.A.	NEVER MARRIED	BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	JOHNS HOPKINS HOSPITAL	Laborer	Chemical Co.		
13a. USUAL RESIDENCE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Md.		Baltimore	YES	504 E. 21st St. 21218	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
William		Ada		White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217-05-7327		MRS. ANNIE GRIFFIN	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:		36 hrs			
IMMEDIATE CAUSE (a)		36 hrs			
5728		1 month			
DUE TO, OR AS A CONSEQUENCE OF					
presumed sepsis					
DUE TO, OR AS A CONSEQUENCE OF					
hepatic failure					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Renal failure, massive obesity					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES NO	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE NOT WHILE		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
AT WORK AS WORK					
22a. I certify that (1) this hospital attended the deceased from					
March 7, 1984, to March 7, 1984, and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (1) (my) (our) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Blange		MD		3/7/84	
22d. PHYSICIAN'S NAME		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
BLANGE		601 N. BROADWAY		Julia Davidson-Randall	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-12-84		Cedar Hill Cmty.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Name		MAR 13 1984		Julia Davidson-Randall	
Randolph J. Collick		2431 E. Oliver St.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician and signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, it should be attached for use as the burial-transit permit. This permit is required for the removal of the body from the place of death to the place of burial or cremation. Pages 2 and 3 should be filled out within 72 hours after death. With the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of the death.

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1. The first part of the report is a general description of the project.

2. The second part is a detailed description of the methodology used.

3. The third part is a description of the results of the study.

4. The fourth part is a discussion of the implications of the findings.

5. The fifth part is a conclusion and a list of references.

6. The sixth part is a list of appendices.

7. The seventh part is a list of figures and tables.

8. The eighth part is a list of abbreviations.

9. The ninth part is a list of acknowledgments.

10. The tenth part is a list of footnotes.

11. The eleventh part is a list of references.

12. The twelfth part is a list of appendices.

13. The thirteenth part is a list of figures and tables.

14. The fourteenth part is a list of abbreviations.

15. The fifteenth part is a list of acknowledgments.

16. The sixteenth part is a list of footnotes.

17. The seventeenth part is a list of references.

18. The eighteenth part is a list of appendices.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical director must make a determination.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06928

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Luelsie Griffin		3/11/84		9:22 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Female		Black		3-5-89		95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Bart City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bart		Burscoun		Domestic		Pvt. Family	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md				Bart		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE		13f. STREET ADDRESS / ZIP CODE	
Louis Griffin		Eliza		727 Druid Hill Lake Dr. Apt. 13 B Balto. Md. 21217		21217	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No.		212-48-2342T		Rev. Marion Bascom		2100 Park Avenue Baltimore, Md. 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 2765 DUE TO, OR AS A CONSEQUENCE OF (b) dehydration DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/10, 19 84, to 3/11, 19 84, that (I) (we) last saw the deceased alive on 3/11/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Mark Darn		DEGREE MD		22c. DATE SIGNED 3/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
MARK DARN		9071 BARTMAN PIKE EC. MD 21043		Burial		3/15/1984	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR Nutter & Sons Funeral Home Inc.		25a. DATE REC'D. BY REGISTRAR	
Arbutus Memorial Park		Baltimore, Maryland		2501 Gwynns Falls Pkwy. Baltimore, Md. 21216		MAR 15 1984	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	
						Julia Davidson-Rendall	

BP

safe

Mary

Tomatic  
Lake Dr. Apt. 12 B. Balto. Md. 21211

Elisa

Orlinda

Louis

2100 Park Avenue  
Baltimore, Md. 21217

No.

Baltimore, Maryland

Burial 2/12/1984 Arbutus Memorial Park  
Witter & Sons Funeral Home Inc.

2501 Gwynns Falls Hwy. Baltimore, Md. 21216



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06929

1. DECEASED NAME (TYPE OR PRINT) <b>PATRICK GORDON Griffin</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3/31/84</b>		2b. HOUR <b>11:05 A.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4-29-64</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>19</b> YRS.	
7a. BIRTHPLACE   STATE OR FOREIGN COUNTRY <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United State</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTO</b>		13c. STREET ADDRESS <b>34 E. OSTEND ST. 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert L. Griffin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARITISA Cecil</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>218-36-1330</b>		17. INFORMANT ADDRESS <b>TISA C. GRIFFEN, same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive G I bleeding</b> <b>2002</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF <b>Complicating Burkitt's lymphoma</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/21</b> , 19 <b>84</b> , to <b>3/31</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/31/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Valden Johnson</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/31/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VALDEN JOHNSON MD</b>		22e. ADDRESS <b>3001 So Hanover St. Balti MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/4/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessops Methodist</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sparks, MD</b>					
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>	
4905 York Road Balto., MD 21212					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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CHILMAN



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1234 York Road, Baltimore, MD 21212

Chief, Henry W. Jenkins & Sons Co.

1234 York Road, Baltimore, MD 21212

1234

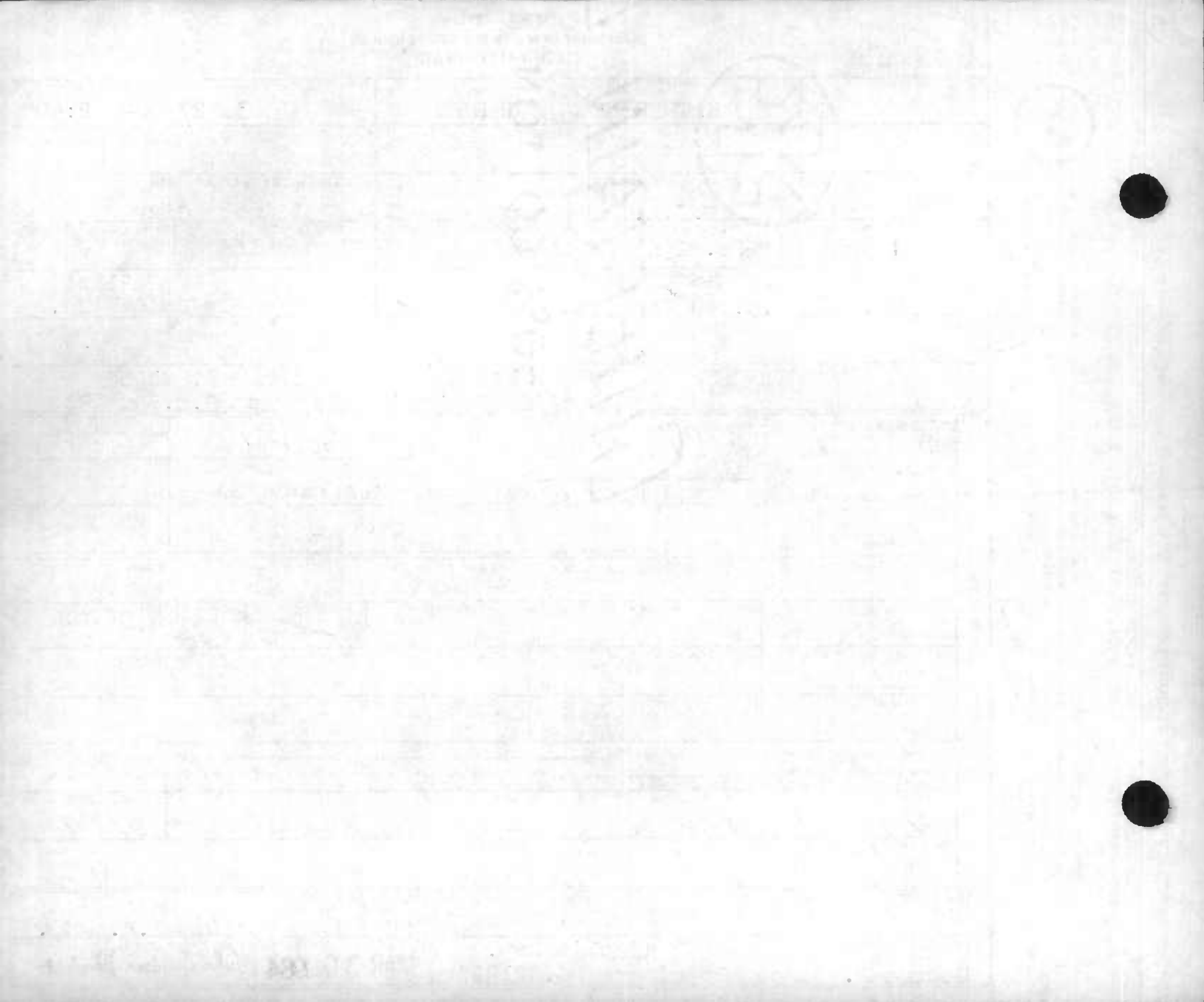
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				06930			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANNA KATHERINE GRIMES				2a. DATE OF DEATH MONTH DAY YEAR 3 27 84		2b. HOUR 2:40 <sup>A</sup> M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7 25 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13e. STREET ADDRESS 21122 301 Magothy Bridge Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Conrad Gishel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Frances Hall		16. ADDRESS Linthicum Md. 21090			
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 10 5695		17. INFORMANT Catherine Skweres P.O. Box 133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) PULMONARY THROMBOEMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS CORONARY ARTERIES DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael E. Velazquez				DEGREE M.D.		22c. DATE SIGNED 3/27	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/29/84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce				4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR MAR 30 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper if present, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examiner will be notified at all.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

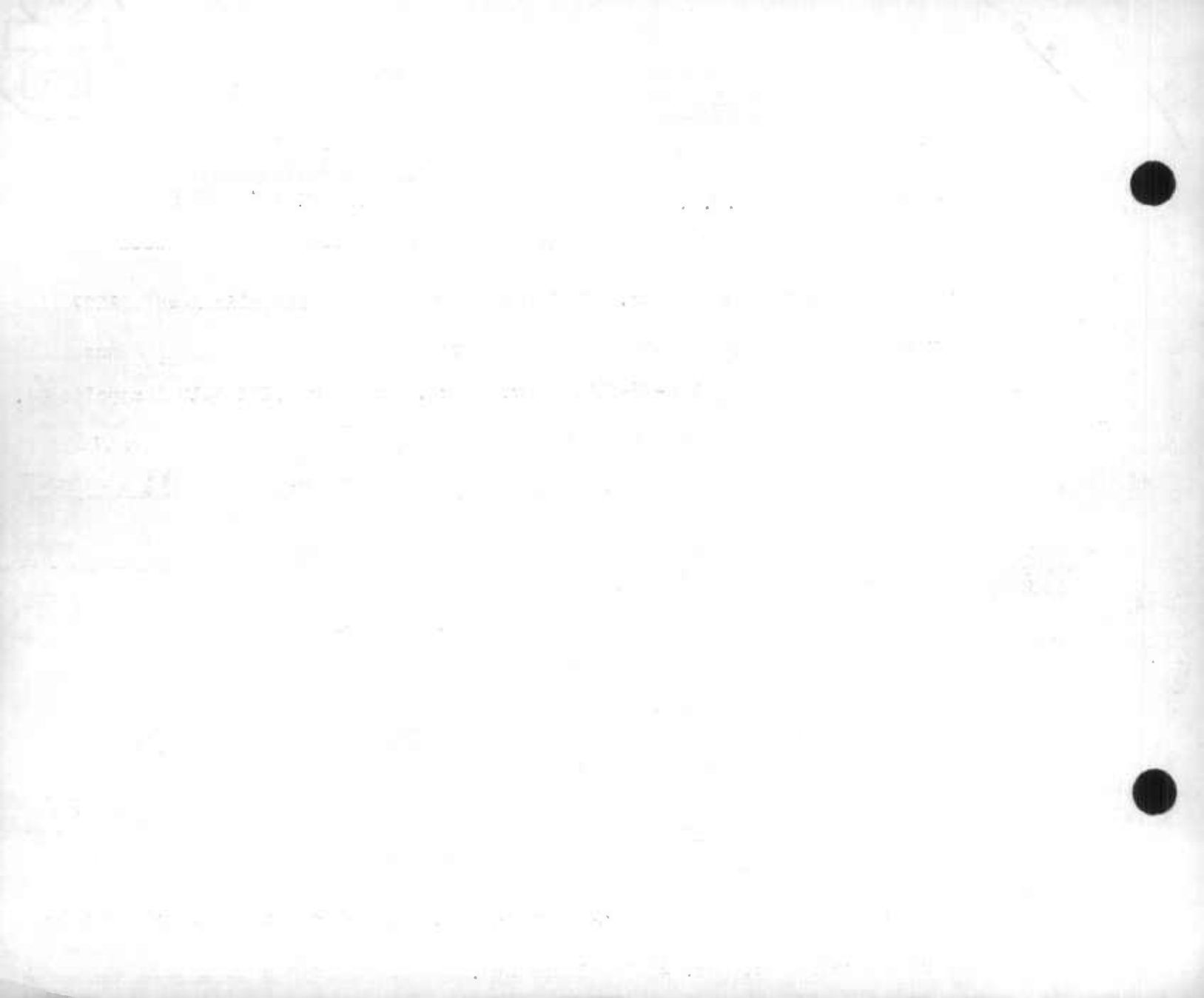
06931

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GLENN A GROH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 04 84</b>		2b. HOUR <b>6:40 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 4 62</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>21</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>---</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto. Highlands</b>		13d. INSIDE CITY LIMITS? <b>NO</b>	
13e. STREET ADDRESS / ZIP CODE <b>4410 Annapolis Road 21227</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Groh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Zenos</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-56-0927</b>		17. INFORMANT ADDRESS <b>21227</b>			
				17. Mr. & Mrs. Frank Groh, III 4410 Annapolis Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> 2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myelogenous Leukemia</b> (c) <b>1983 - present</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Massive Hepatic Necrosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) this hospital attended the deceased from <b>3/1</b> , 19 <b>84</b> , to <b>3/4</b> , 19 <b>84</b> , and that (ii) (we) (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <b>Kevin J. Twonig</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kevin J. Twonig</b>		22e. ADDRESS <b>N. Wolfe St. Baltimore, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 8 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for this certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72-hour certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 12, 1984</b>		2b. HOUR <b>12:28A</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 13, 1912</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>	
14. FATHER'S NAME <b>RICHARD</b>		15. MOTHER'S MAIDEN NAME <b>JOSEPHINE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>236-10-4995</b>		17. INFORMANT ADDRESS <b>MAGNOLIA GROOMS 914 BONNAPARTE AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial CVA (cerebrovascular accident)</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3min</b> <b>2wks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>84</b> , to <b>3/12</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mindy Shapiro</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/12/84</b>	
22d. PHYSICIAN'S NAME (TYPE COMPLETE) <b>Mindy Shapiro</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL 601 N. BROADWAY</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/16/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GROOMS CEM. LOT</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Louisa VA</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>ROY O. DYETT 4600 LIBERTY HGTS. AVE</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>She Davidson-Randall</b>			

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MARCH 12, 1964

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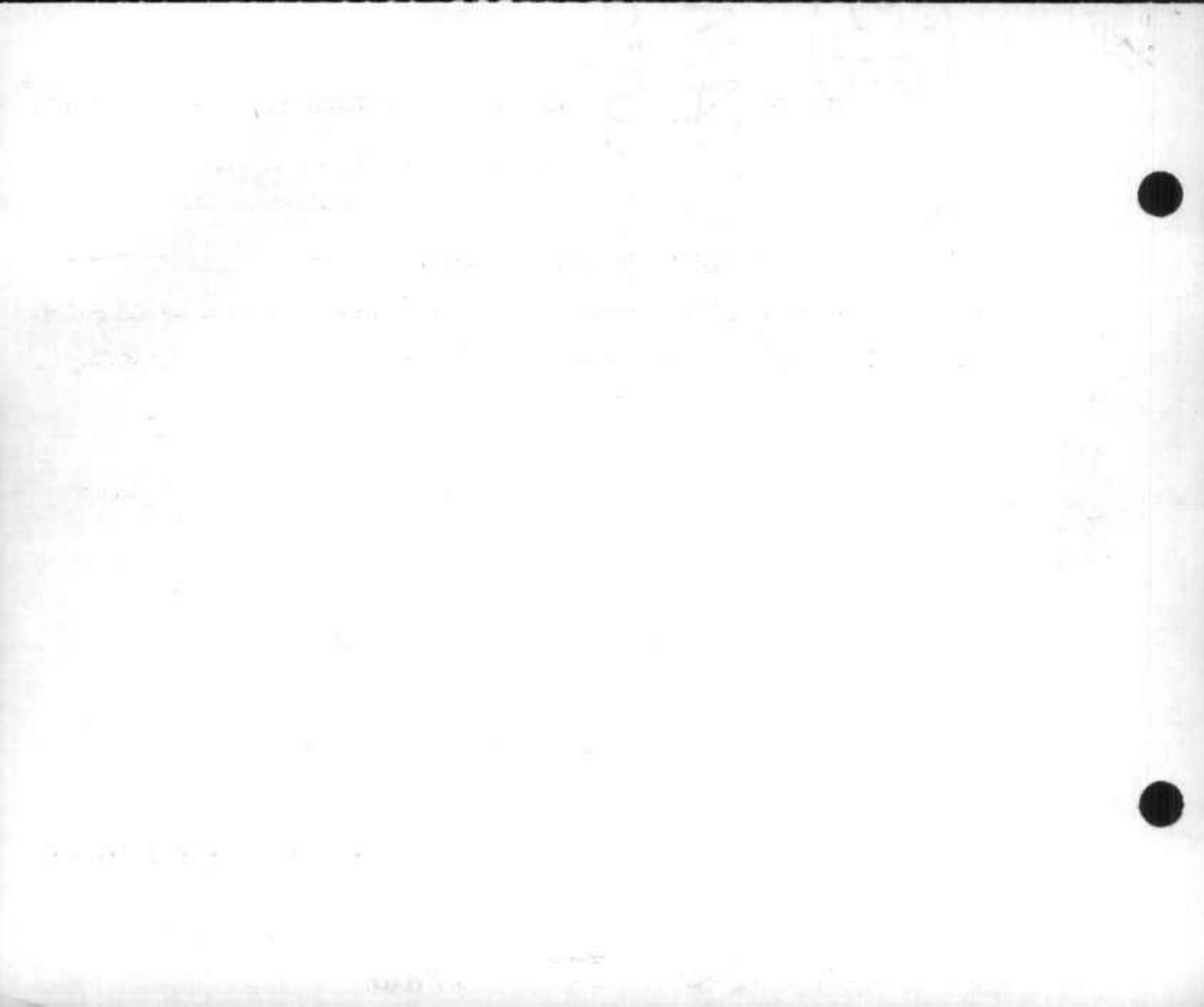
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with 22b. Complete the death with the State Dept. of Health and Mental Hygiene prior to burial (interment, or cremation). IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to autopsied.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06933

1. FOR STATE REGISTRAR		REG. NO.		P	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
JUSTIN W. GROVE				MARCH 15, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
MALE		WHITE		NOV. 10 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
MARYLAND		U.S.A.		4 MONTHS	
12. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		HARFORD		Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
ERNEST W. WINSTON		BARBARA S. GROVE		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
		FAMILY RECORDS		cardiac arrest heart failure multiple congenital anomalies of heart and great vessels	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3/14/84		Repair congenital heart anomaly		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 13, 1984, to March 15, 1984, that (I) (we) last saw the deceased alive on March 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		David Johnson		3/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
DAVID JOHNSON		600 N. WOLFE ST. BALTO. MD Johns Hopkins Hospital		21205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MARCH 19, 1984		DULANEY VALLEY	
24. FUNERAL DIRECTOR NAME ADDRESS		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
EVANS CHAPEL OF CHIMES 2325 YORK RD		MARCH 3 1984		Lia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				06934			
1. DECEASED NAME (TYPE OR PRINT) <i>William Bruce Grove</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>03-03-1984</i>		2b. HOUR <i>8:55 P M</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 16 1928</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD</i>	
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>903 COOKS LANE APT. 5-A</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hvy. Mach. Opr.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>QUARRY</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <i>MD</i>		13b. COUNTY <i>BALTO. CTY</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13e. STREET ADDRESS / ZIP CODE <i>903 COOKS LN. APT 5-A 21229</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Grove</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>NANNIE DENVERS</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-24-1893</i>		17. INFORMANT <i>MR. BRUCE P. GROVE</i>		ADDRESS <i>300 FIFTH AVE. HANDS DOWN, MD 21229</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Widespread Small cell Cancer of Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>6 months</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 M. 15</i>							15 M. 15
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>							
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Lung Cancer</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 19 83</i> to <i>March 19 84</i> , that (I) (we) last saw the deceased alive on <i>Mar 2, 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Elwood H. La Brosse, MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>03-03-1984</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Elwood H. La Brosse, MD</i>				22e. ADDRESS <i>3459 St. John Lane, Ellicott City, MD 21043</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>3-5-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Worship Mom Ac.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Carmville Balto. Md</i>	
24. FUNERAL DIRECTOR NAME <i>SLACK FUNERAL HOME</i>				ADDRESS <i>P.O. Box 205 Quincy City MD</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 16 1984</i>	
				25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>			

LIBEL

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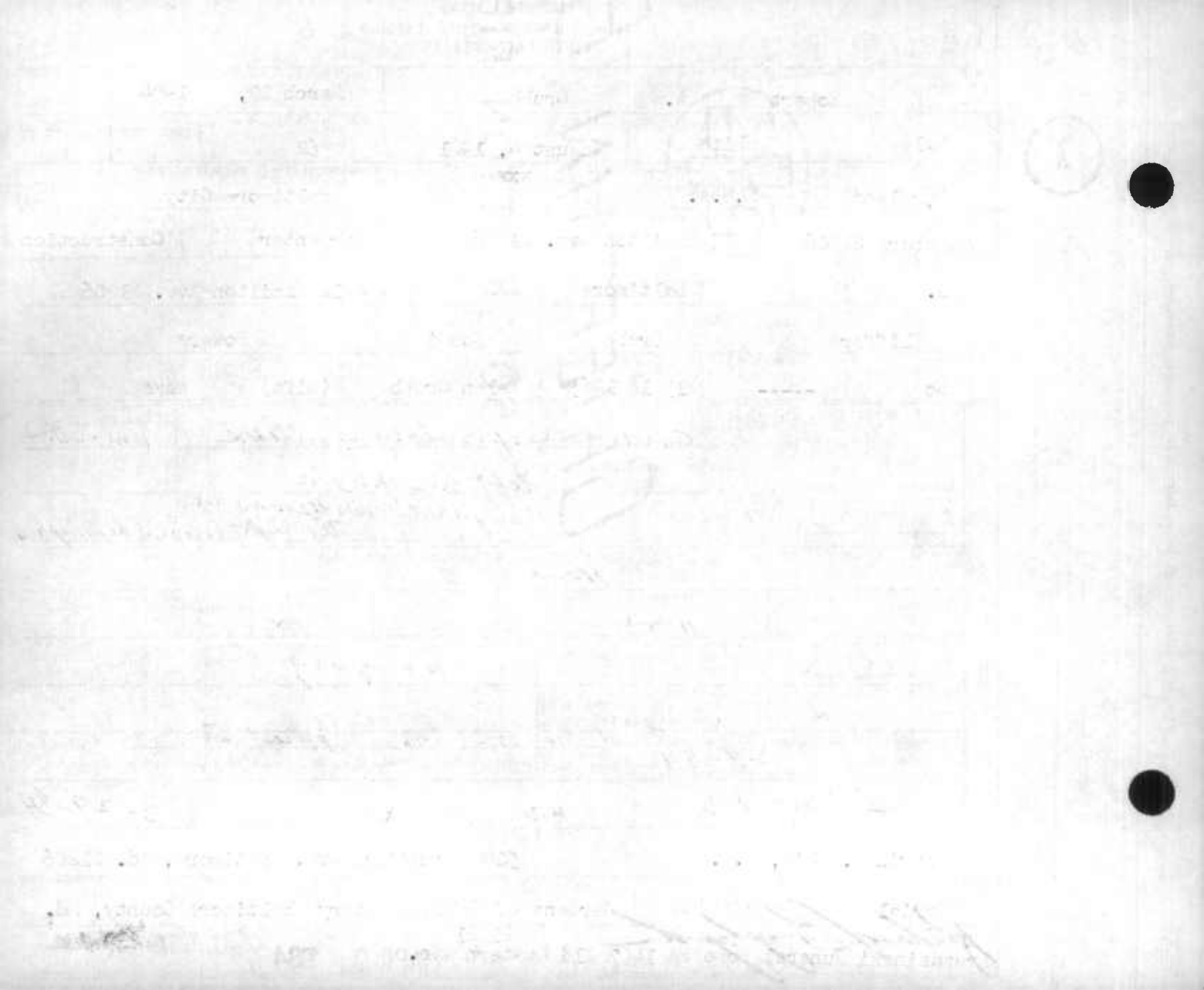
02-03-1971  
[Faint, mostly illegible text follows, appearing to be a series of entries or a list, possibly related to a legal or administrative record.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Robert A. Grubb				March 27, 1984		M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		August 4, 1921		62 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Raspeburg 21206		4912 Hamilton Ave. 21206				Carpenter		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4912 Hamilton Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Clifford Grubb				Naomi Bowers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				213 16 1965		Helen Grubb (Wife) Same			
18. CAUSE OF DEATH (Enter: only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 1910 DUE TO, OR AS A CONSEQUENCE OF (b) <u>left hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malignant mass lesions in the right cerebral hemisphere</u> APPROXIMATE PERIOD BETWEEN ONSET AND DEATH <u>1 month</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		None							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19		no injury					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
		no injury							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-25-</u> 19 <u>76</u> , to <u>present date</u> 19 <u>84</u> , that (I) (we) lost the deceased above on <u>3-9-84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>F. S. Abid, M.D.</u>		M.D.						3-29-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Farid S. Abid, M.D.				5002 Frankford Ave. Baltimore, Md. 21206					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/30/84		Gardens Of Faith Cemetery		Baltimore County, Md.			
24. TO FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Brudzinski Funeral Home PA 1407 Old Eastern Ave				21221 APR 2 1984		<u>John Davidson-Randall</u>			

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET M. GRUSCH			2a. DATE OF DEATH MONTH DAY YEAR 3 - 30 - 84		2b. HOUR 19:05 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 19 22		
6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		
12b. KIND OF BUSINESS OR INDUSTRY Hospital		13a. STREET ADDRESS 575 Beechfield Ave. 21229				
13b. COUNTY Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Howard Young		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-6549		17. INFORMANT ADDRESS Joseph H. Grusch 21229 575 Beechfield Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION, SHOCK 4100 } DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). HYPERTENSION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 3-30-84 to 3-30-84, the (1) (we) last saw the deceased alive on 3-30-84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Aidan E. Walsh M.D.		DEGREE M.D.		22c. DATE SIGNED 3-30-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aidan E. Walsh M.D.		22e. ADDRESS 333 ST. PAUL 21202				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/3/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 above as injury, or other traumatic event, the medical examiner will file the medical report of cause.

25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
APR 2 1984

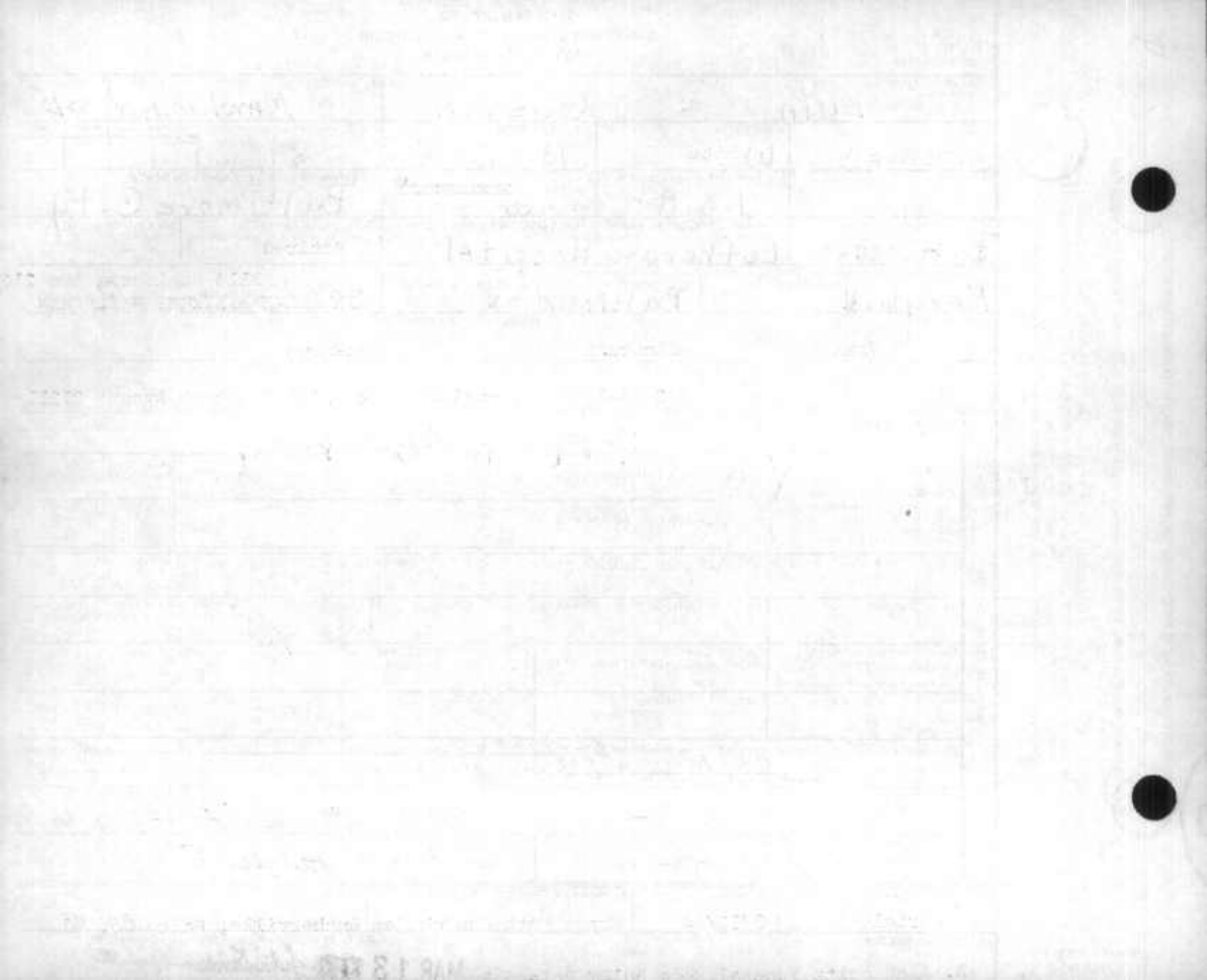


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				06937					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR					
Lula E. Guerin				March 10, 1984				8:15 M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		10 10 94		89 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> <del>SEVERAL TIMES</del> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Ohio		U.S.A.				Baltimore City MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Lutheran Hospital 2216						Retired					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3114 Remington Ave 212			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Frank Gilchrest				unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				042-05-3808		Edward Jeunette-3603 Chestnut Avenue 21211							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis + dehydration</u> <u>0389</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>02-12-84</u> 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>03-10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE		22c. DATE SIGNED					
Sissrs Ansh								3/10/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Sissrs Ansh						Lutheran Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				3/12/84		Grace Meth Church Cem				Lutherville, Balto Co. Md			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE	
A. Alan Seitz Funeral Home				MAR 13 1984								Julia Davidson	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 6 7 3 8  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Roscoe GULLICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 5, 1984</b>			2b. HOUR <b>10:05<sup>A</sup><sub>M</sub></b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 17 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto. City</b>		13c. CITY OR TOWN <b>Balto. City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>218-10-5655</b>			17. INFORMANT <b>Joseph W. Curtis</b>			ADDRESS <b>607 Gold St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, with multiple pulmonary abscesses.</b> 5314 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastric septic ulcer with mild gastrointestinal bleeding</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 2</b> , 19 <b>84</b> , to <b>March 5</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 5</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <b>Bruce Shames</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/5/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce Shames, M.D.</b>			22e. ADDRESS <b>c/o Maryland General Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Chatman-Harris Fh</b>					ADDRESS <b>1701 McCulloh St.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Baltimore City

Harvard General Hospital

Baltimore

Gastric septic ulcer with mild gastroenteritis. Gastric septic ulcer with mild gastroenteritis.

xxx x

March 2 84 March 2 84 March 2 84

xxx

3/2/84

c/o Harvard General Hospital

Bruce Shames, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas E. Gump			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 24 19 84			2b. HOUR M 1:12 P		
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 7-15-51	6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 24 19 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3800 Blk. E. Baltimore St (in auto)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3803 E. Lombard Street 21224			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Gump			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Gunzelman 21221					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-60-3880		17. INFORMANT ADDRESS Mrs. Ann Gump 164 Virginia Ave 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute ethanol intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 3/25/84		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-28-84		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY Balto. Md.		
24. FUNERAL DIRECTOR NAME Joseph N. Zannino			ADDRESS 263 S. Conkling		25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. SIGNATURE <i>Julia Davidson Nordell</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

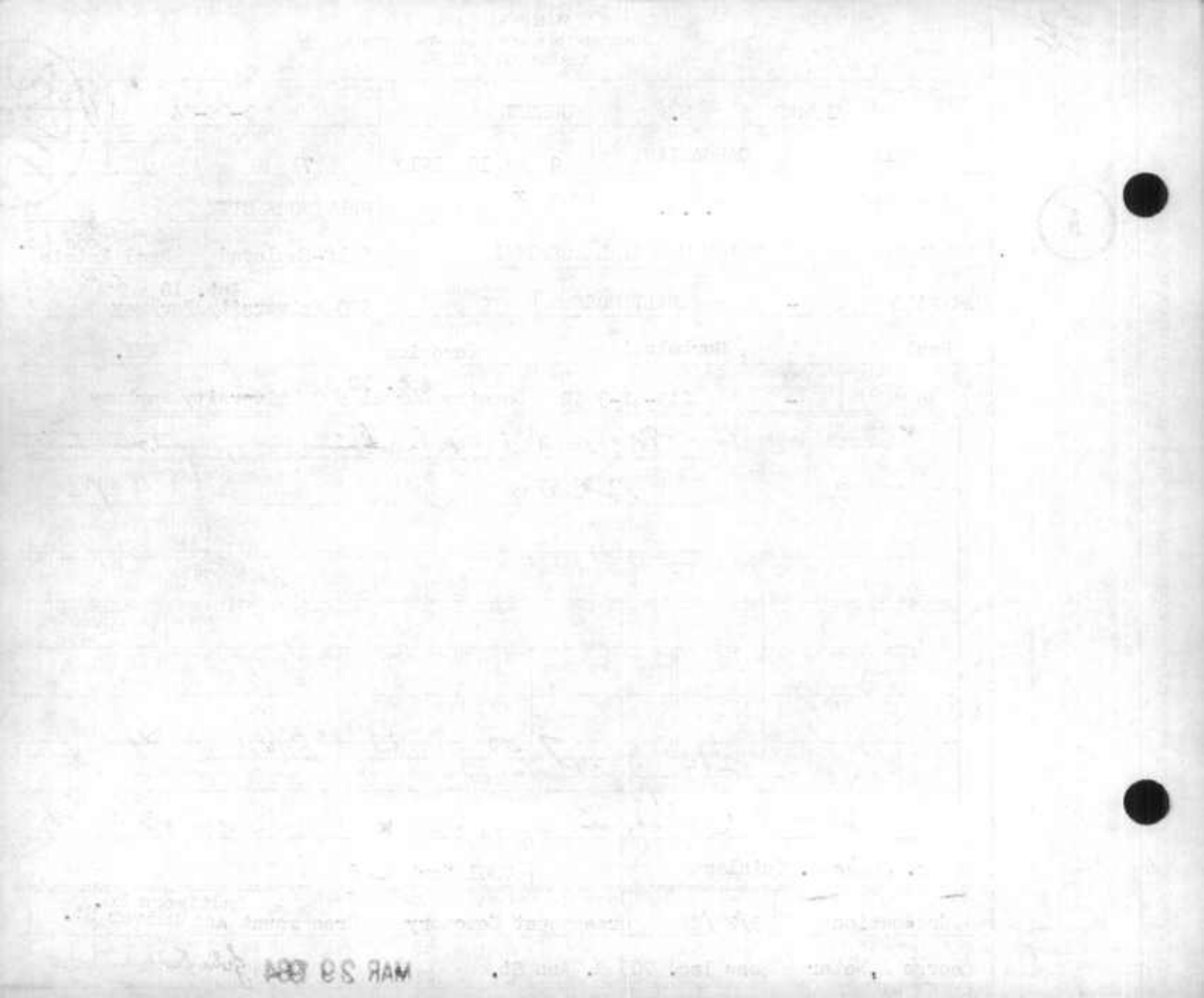
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
ALFRED M. GURBEL					3-28-84				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. HOUR	
MALE		CAUCASIAN		9 18 1912		71 YRS.		4:45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL				Self-Employed		Soda Co. Real Estate	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE MARYLAND					13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Paul Gurbelski					Veronica UNK.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No -					213-42-3942		Dorothy Gurbel Apt. 10 R 500 University Parkway		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>15 yrs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> 19 <u>84</u> to <u>3/8</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>James A. Quinlan</u>					DEGREE		22c. DATE SIGNED		
					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/29/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Dr. James A. Quinlan					7801 York Road				
23a. BURIAL, CREMATION, REINTERMENT (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN STATE		
Cremation			3/29/84		Greenmount Cemetery		Baltimore Md. Greenmount and Oliver St.		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George A. Weber & Sons Inc. 705 S. Ann St.					MAR 29 1984		Julia Davidson-Randall		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06941

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Marie Garry</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 9 84</b>			2b. HOUR 12 <sup>noon</sup> <sub>M</sub>			
3. SEX <b>Female</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 6 19</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>65</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balt.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>—</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Medical Center</b>				12. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1028 E. Fort Ave</b>	
14. FATHER'S NAME (TYPE OR PRINT) <b>Peter J. Gaudin</b>		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Josephine Zoback</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>315-03-9241</b>		17. INFORMANT <b>William Garry</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>3320</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Chronic Aspiration</b> (c) <b>Parkinson's</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):		APPROXIMATE INTERVAL BETWEEN (a) AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> 19 <b>82</b> to <b>March 9</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>March 9</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Sandra L. Howard</b>				DEGREE <b>MD.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/9/84</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sandra L. Howard</b>				22d. ADDRESS <b>1600 S. Charles St 21230</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE <b>3/12/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		23d. LOCATION STREET CITY COUNTY <b>1511 E. Fort Ave. Md.</b>			
24. FUNERAL DIRECTOR <b>Charles H. Stevens</b>		24b. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>		24c. REGISTRAR'S SIGNATURE <b>—</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove all other pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06942

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST LILLIAN HAAS			MONTH DAY YEAR 3 3 84			5:40 AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE	CAUCASIAN	MONTH DAY YEAR 10 02 22		61 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MARYLAND	USA	BALTIMORE		BALT CITY				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALT. CITY	SINAI HOSPITAL			HOUSEWIFE		AT HOME		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS		
13a. STATE COUNTY MD BALTO.			13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13c. FOREST #21209 2422 FOREST GREEN RD. BALTO., MD 21209		
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL WOLFSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			216 M 8158			MILLARD HAAS		
			2422 FOREST GREEN RD. BALTO., MD 21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 20 TO METASTATIC CARCINOMA OF COLON (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/3/84 to 3/5/84, that (I) (we) last saw the deceased alive on 3/3/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
BENJAMINE E. GAINES			MD			3/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
BENJAMINE E. GAINES			BALT. SINAI HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	
BURIAL			MAR. 4, 1984	OHEB SHALOM			REISTERSTOWN BALTO. MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				MAR 6 1984		WILSON RENDALL		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SOLOMON S. HACK</b>		2a. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>22</b> YEAR <b>84</b>		2b. HOUR <b>7:19 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>02</b> DAY <b>07</b> YEAR <b>14</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> <del>70</del> YRS.	IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND US</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Baltimore General Hospital</b>		12a. USUAL OCCUPATION (BROKER) <b>XXXXXXXXXX</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13a. COUNTY <b>BALTO</b> 13a. CITY <b>RANDALLSTOWN</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE <b>8405 ALLENSWOOD RD #21133</b>	
14. FATHER'S NAME FIRST <b>SOLOMON</b> MIDDLE <b>S.</b> LAST <b>HACK</b>		15. MOTHER'S MAIDEN NAME FIRST <b>IDA</b> MIDDLE <b>—</b> LAST <b>Levinson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>216-10-9472</b>		
17. INFORMANT <b>MRS. CARY XXXXXXXX</b>		ADDRESS <b>8405 ALLENSWOOD RD., RANDALLSTOWN, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE CARDIAC ARRHYTHMIAS. ACUTE MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE CORONARY ARTERY DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>				
19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> <b>1984</b> , to <b>3-22</b> <b>1984</b> , that (I) (we) last saw the deceased alive on <b>3-22</b> <b>1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Angelica Suenas-Varela MD</b>	DEGREE <b>MD</b>	22c. DATE SIGNED <b>MARCH 22-84</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANGELICA SUENAS-VARELA</b>
22e. ADDRESS <b>3001 S. HANOVER STREET BALTO. MD. 21230</b>		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3-25-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM MEM. PARK</b>	23d. LOCATION CITY OR TOWN <b>REISTERSTOWN BALTO.</b> STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1984</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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MAR 28 1954

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KATHRYNE ESTELLE HADERLY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 1, 1984</b>			2b. HOUR <b>1:15 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 31, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept. Head</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Union</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1034 Woodson Rd. 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Blest</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>349-10-4096</b>		17. INFORMANT ADDRESS <b>Mrs. Frances M. Smith Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>9120</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 1 hr</b> <b>~ 3 hrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Recent refractive vision &amp; peritonitis @ CHF</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>unmox 2/15/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alan Kimmel</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3-1-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan Kimmel, M.D.</b>				22e. ADDRESS <b>222 W. Coldspring Lane Balto., Md. 21210</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial-Transit</b>		23b. DATE <b>Mar. 2, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chapel Hill South</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Worth, Cook Co., Illinois</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>				ADDRESS <b>6500 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodella</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Cordian Gordon Hagans				2a. DATE OF DEATH MONTH DAY YEAR 3 29 84				2b. HOUR 7 20 PM					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 3 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilson, N. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman		12b. KIND OF BUSINESS OR INDUSTRY Shipping					
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 136 Denison Street Baltimore, Maryland 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Bert Hagans				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Lyde									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 218-03-5460A		17. INFORMANT Mrs. Deborah Hagans		ADDRESS 136 N. Denison St. Baltimore, Maryland 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>1550</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Cancer of Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>3/29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE <u>J. Taylo</u> DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>3/29</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jimmy Taylor</u>				22e. ADDRESS <u>2600 LIBERTY HEIGHTS AVE.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/4/1984		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Nutter & Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216						25a. DATE REC'D. BY REGISTRAR APR 4 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

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2501 Wynns Falls - N.Y. - Littleton, Md. 21116  
 Mutter & Sons Funeral Home Inc.  
 - 4/1984 - Arbutus Memorial

Butter & Sons Funeral Home Inc. - 4/1984 - Ardatus Memorial Park

Ad. 1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE J. HAHN JR.			2a. DATE OF DEATH MONTH DAY YEAR 3 13 84			2b. HOUR P. 2:50 M.					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 29 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) APPRAISER		12b. KIND OF BUSINESS OR INDUSTRY STATE OF MD.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1526 TUNLAW RD. 21218			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE J. HAHN SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMINA SCHUTTE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS PATRICIA HAHN (DGHTR) SAME ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> , 19 <u>84</u> , to <u>3-13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.											
22b. SIGNATURE <u>George M Boyer MD</u>			DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/13/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George M Boyer</u>			22e. ADDRESS <u>Mercy Hospital Balt. MD</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/16/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME STACHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213					25a. DATE REC'D. BY REGISTRAR MAR 16 1984					25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed and signed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAN E R HALL</b>			2a. DATE OF DEATH MONTH <b>03</b> DAY <b>22</b> YEAR <b>84</b>			2b. HOUR <b>8<sup>25</sup></b> AM	
1. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>31</b> YEAR <b>1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. (STATE) <b>Ind.</b>		13b. COUNTY <b>Balt.</b>		13c. CITY OR TOWN <b>Balt.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>?</b> MIDDLE <b>De Jollo</b>		15. MOTHER'S MAIDEN NAME FIRST <b>unknown</b> MIDDLE <b></b> LAST <b></b>		13e. STREET ADDRESS / ZIP CODE <b>1019 De Soto Rd. 21223</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>Raymond D. Hall 1019 De Soto Rd. 21223</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest.</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Breast Carcinoma lung metastasis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. <b>2 weeks</b> <b>8 years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>03-7</b> , 19 <b>84</b> to <b>03-7</b> , 19 <b>84</b> , that (I) (we) lost the deceased alive on <b>03-21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michele Gordon</b>				DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>3-22-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michele Gordon</b>				22e. ADDRESS <b>St. Agnes Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>3-24-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Ind.</b>	
24. FUNERAL DIRECTOR NAME <b>John J. Connor, Jr.</b> ADDRESS <b>901 Hollins St. Baltimore, Md. 21223</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Connor, Jr.</b>			

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6 1 30 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06749

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SCOTT B HALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03/31/84</b>			2b. HOUR <b>5:28pm</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 18, 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1yr 1 month</b> WRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>1 1 0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>Randallstown, Md. 8503 Glen Michael Lane 21133</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Hall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Victoria Regalbuto</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT ADDRESS <b>21133 Reno Regalbuto 3813 Brownhill Rd. Randallstown</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5849 IMMEDIATE CAUSE (a) Ventricular Fibrillation</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Renal Failure</b>								<b>12 hours</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Septic Shock</b>								<b>48 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10) <b>Citrobacter Meningitis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>Johns Hopkins</b>		CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 29, 19 84</b> , to <b>March 31, 19 84</b> , that (I) (we) lost saw the deceased alive on <b>March 31, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R Scott Strahlman, MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>3/31/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R Scott Strahlman</b>				22e. ADDRESS <b>Johns Hopkins</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr 3, 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Dippel Funeral Homes, Inc.</b>				ADDRESS <b>7110 Belair Road Baltimore, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These forms are to be retained by the funeral director and must be filed with the State Dept. of Health and Mental Hygiene prior to the burial. Page 1 and 2 should be filed within 24 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury or other terminal event, medical examiner's certificate must be attached.





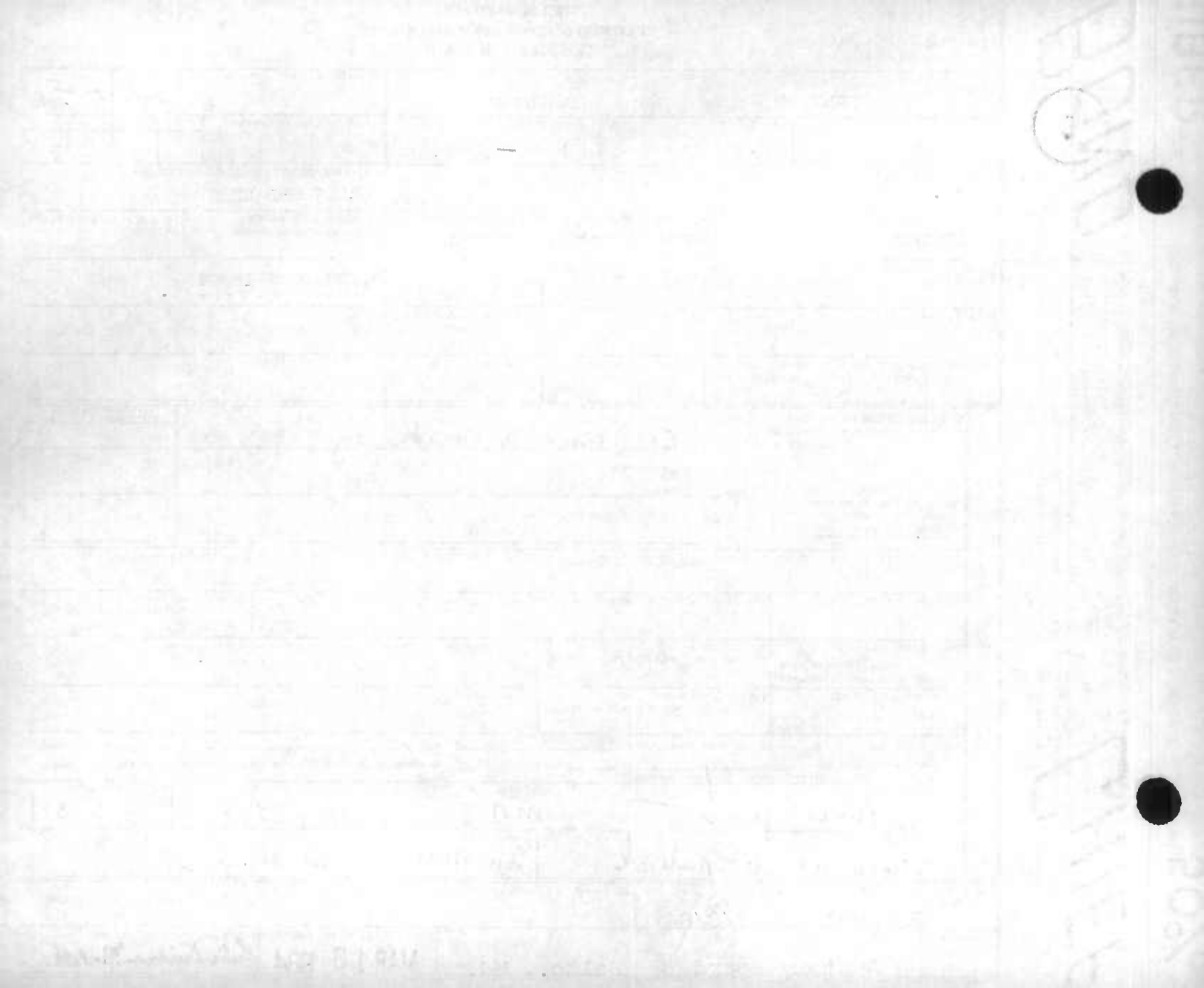
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY HAMILTON</b>				MONTH <b>3</b> DAY <b>6</b> YEAR <b>84</b>		2b. HOUR <b>5<sup>45</sup> PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>6</b> YEAR <b>84</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>422 ILCHESTER AVE. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17b. INFORMANT		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7650 Extreme prematurity</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Julia Davidson-Randall</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-6-84</b>			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julia Davidson-Randall</b>		23b. ADDRESS <b>Union Memorial Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the coroner notified.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Robert Hamlin				3-23-84	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE	Black	MONTH DAY YEAR		69 YRS.	
		3-15-15		8 MONTHS 8 HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	USA			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Federal Hill Np. Center				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Md.			Baltimore	1300 E. Lanvale St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Lee Hamlin		Clara Hamlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		160-18-3345A		Luevenia Hamlin 1300 E. Lanvale St. Apt. 404	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cerebrovascular Disease					
4379 DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 1st 1983, to March 23 1984, that (I) (we) last saw the deceased alive on March 16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
George Taler, M.D.				3/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
GEORGE TALER, M.D.		600 LIGHT ST BALT. MD. 21230			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		3/29/84		Baltimore Cemetery Baltimore, Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H Inc. 1101 E North Avenue		MAR 27 1984		Davidson-Randall	

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102-18-2-10-1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06952

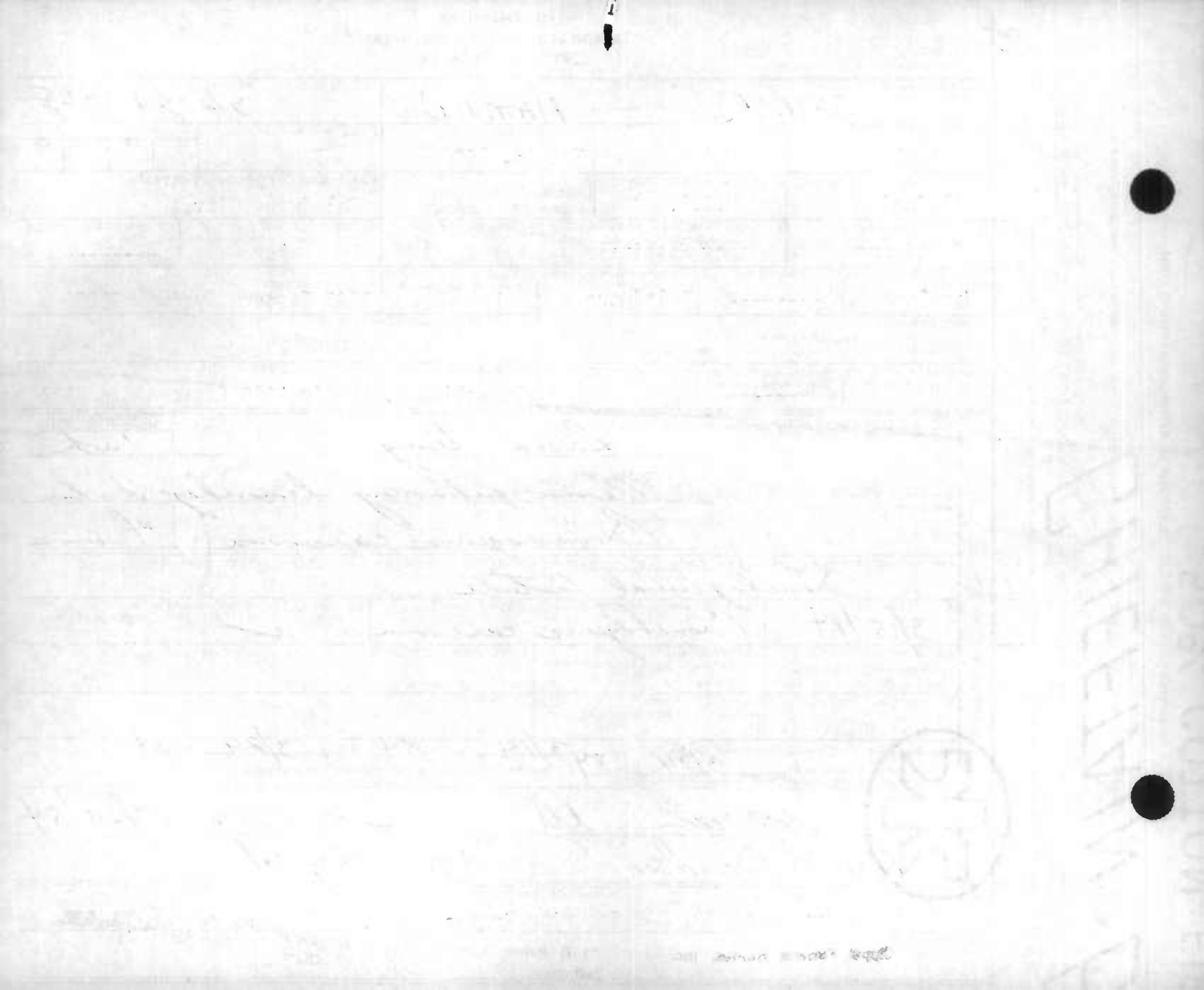
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
SHIRLEY		HAMLIN		3/29/84		9:45		P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		May 16, 1926		57 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois		U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Mercy Hospital		Homemaker		-----			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		-----		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2343 Eastern Avenue 21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
UNKNOWN		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		-----		Cornelius J. Hamlin 2343 Eastern Ave 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive pulmonary embolus 2 wks</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic carcinoma 4 mos</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Bronchopulmonary fistula</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
3/15/84		Bronchogenic carcinoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> 19 <u>84</u> , to <u>3/29</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Ann B Davidson</u>		MD				3/29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Ann B Davidson		Mercy Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Mar 30, 84		Security Process, Inc.		Baltimore, MD			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR (NON-TRANSMISSION) REGISTRAR'S SIGNATURE					
Opel Funeral Homes, Inc.		7110 Belair Road Baltimore, Md		MAR 30 1984					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/83  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 is any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Samuel Hammerman</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-24-84</b>				2b. HOUR <b>8:40 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 27 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW HAMPSHIRE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Levin Dale Nursing Center Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUTCHER</b>		12b. INDUSTRY <b>ANDERSON'S MTR.</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3510 HILLSMERE RD. 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDEL HAMMERMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE BERNBAUM</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-14-2145</b>		17. INFORMANT <b>MRS. BETTYE HAMMERMAN</b>		3510 HILLSMERE RD. BALTO., MD 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer prostate with Metastases to Bones</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>8:35 PM 3/24/84</b> , to <b>3/24/84</b> , that (a) (we) lost saw the deceased alive on <b>8:35 PM 3/24/84</b> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>YCHIN TUN</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/24/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>YCHIN TUN</b>				22e. ADDRESS <b>Levin Dale Geriatric Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>MAR. 26, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI ZION</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1984</b>					
6010 REISTERSTOWN RD. BALTO., MD 21215						25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06754

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sylvia E. HAND			2a. DATE OF DEATH MONTH DAY YEAR March 3, 1984			2b. HOUR 2:15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 30, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4509 Glenarm Avenue 21206				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson	
12b. KIND OF BUSINESS OR INDUSTRY Dept. Store							
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4509 Glenarm Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Heiner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Fredericks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-6717		17. INFORMANT ADDRESS James E. Hand 4509 Glenarm Ave 21206			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4029

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from OCTOBER, 1983, to MARCH, 1984, that (I) (we) last saw the deceased alive on JAN 31, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

Fausto Q. Aquino, Jr., M.D.  
Ruben S. Sabastian, M.D.

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

3-5-84

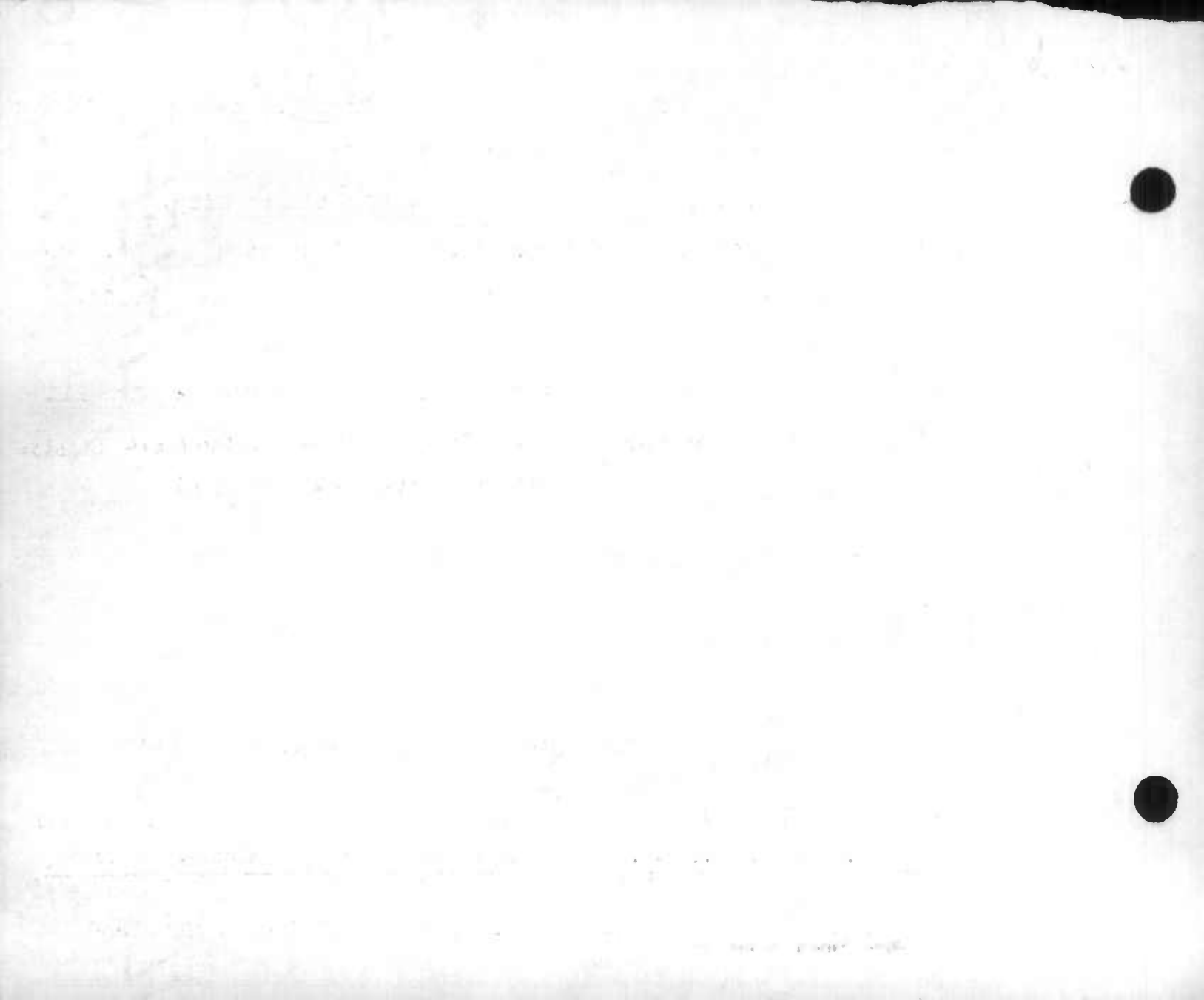
22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

8715 Harford Road Baltimore, MD 21234  
2314 E. Joppa Road Baltimore, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 6, 84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc.		ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR MAR 6 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARIE E. HANNUM			2a. DATE OF DEATH MONTH DAY YEAR 3-26-84		2b. HOUR 5:52 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 19 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Gen'l		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic work		
13a. STATE md.		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. STREET ADDRESS 3611 MARION AVE		
14. FATHER'S NAME FIRST MIDDLE LAST James Jenkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Robinson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-30-6437		17. INFORMANT ADDRESS MRS. EVA PIUN 4412 ELDERON AVE.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-2, 1984, to 3-26, 1984, that (I) (we) last saw the deceased alive on 3-26, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Antonio S. Ravidia, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-26-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO S. RAVIDA		22e. ADDRESS NORTH CHARLES GEN. HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/29/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK.		
23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD.						
24. FUNERAL DIRECTOR NAME ADDRESS Chatman-Aardis F4 1701 McCulloh St.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 10 1984 John Davidson-Rendell				

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EXCLUDED FROM AUTOMATIC  
DOWNGRADING AND  
DECLASSIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JUNE S. HARGROVE			2a. DATE OF DEATH MONTH DAY YEAR 3-18-84			2b. HOUR M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6-5-1928		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2505 PARKTRAIL RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REPRESENTATIVE		12b. KIND OF BUSINESS OR INDUSTRY C&P TELEPHONE	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21234 2505 PARKTRAIL RD.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. SCHAUB				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL V. CAYWOOD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-24-2254		17. INFORMANT ADDRESS 21234 Mrs. Deborah A. Kailer - 2505 Parktrail Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RESPIRATORY FAILURE (EMPHYSEMA) 4920 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COR PULMONALG									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on above, (or we) did not view the body after death. _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE H. Roubik				DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 19 March 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3-22-84		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME Dorothy Miller - 7527 Bayford Rd.				25a. DATE RECEIVED BY REGISTRAR MAR 19 1984		25b. REGISTRAR'S SIGNATURE John A. Kailer			

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JUNE 2, HARRIS

F W 2-14-5

MD BALTO

2003 PATENT RD BALTO

21334

MD BALTO

HARVEY V. CHAPMAN

MD 24-2500 1st. Bldg. A. Keller - 2003 PATENT RD

CHAPMAN RESIDENTIAL PARK (COMMUNITY)

COA

MD 24-2500

1950

2-14-5

2003 PATENT RD



Items #63/15/84 mtb F#589

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06957

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Phillip R. Harrell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 28 1984</b>		2b. HOUR <b>3:45 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 13 1951</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1743 Druid Hill Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>General Hospital</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Harrell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Purvis</b>		13e. STREET ADDRESS / ZIP CODE <b>1743 Druid Hill Ave. Baltimore, Maryland 21217</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>218-62-5589</b>		17. INFORMANT ADDRESS <b>Annie Harrell Baltimore, Maryland 21217</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>2791</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acquired Immune Deficiency Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Frank Poll</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-2-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. FRANK POLL</b>		22e. ADDRESS <b>655 N. Wolfe St. Baltimore, MD 21205</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/3/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Nutter &amp; Sons Funeral Home Inc. 2501 Gwynns Falls Parkway Balto. Md. 21216</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAR 02 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

1301 Guyton Falls Parkway Balto. Md. 21215  
 Mutter & Sons Funeral Home Inc.  
 3/3/1984 Mt. Auburn Cemetery Baltimore, Maryland

No. 218-62-1282 Annie Harrell Baltimore, Maryland 21217  
 Charles Harrell Annie Harrell  
 Maryland Baltimore X Ave. Baltimore, Maryland 21217  
 Baltimore 1743 Druid Hill Avenue  
 Security Guard Hospital  
 Lt. General  
 X Baltimore City

Wife Black Y 10 1981 34 36  
 Harrell M. Phillip  
 28 1981 34 36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06958

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <u>BABY BOY</u> <u>HARRIS</u> <u>OLSZEWski</u>		MONTH DAY YEAR <u>3</u> <u>31</u> <u>84</u>		HOUR MIN <u>4</u> <sup>00</sup> <u>A</u>	
3. SEX <u>M</u> Male	4. RACE <u>W</u> White	5. DATE OF BIRTH MONTH DAY YEAR <u>3</u> <u>30</u> <u>84</u>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>0</u> <u>0</u> <u>5</u>	IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN <u>5</u> <u>30</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City,</u> MD.		
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hospitals</u>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>None</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		
13a. STATE <u>Maryland</u>	13b. COUNTY <u>-----</u>	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>127 S. Ann Street 21231</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Albert J.</u> <u>Olzewski</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Katherine</u> <u>Ditch</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>None</u>	17. INFORMANT ADDRESS <u>Albert Olzewski</u> <u>Baltimore, Md.</u> <u>127 S. Ann Street 21231</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERINATAL ASPHYXIA</u> <u>7650</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>PREMATURE</u> (c) <u>CERVICAL DILATATION (WEAKNESS)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ANEMIA, RESPIRATORY DISTRESS SYNDROME</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> , 19 <u>84</u> , to <u>3-31</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3-31</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Emmanuel M.D.</u>	DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>3-31-84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Bartlett Jr M.D.</u>	22e. ADDRESS <u>Baltimore City Hosp</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>Apr 5, 84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co., Md/</u>		
24. FUNERAL DIRECTOR NAME <u>Dippel Funeral Homes, Inc.</u>	ADDRESS <u>7110 Belair Road</u> <u>Baltimore, Md.</u>	25a. DATE REC'D. BY REGISTRAR <u>APR 10 1984</u>			
		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			



*[The body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is arranged in several paragraphs across the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH #17200000 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										6 9 5 9	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>AKASHARIA</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3/21/84</b>		2b. HOUR <b>8:45</b>		2c. DATE PRONOUNCED DEAD <b>3/21/84</b>	
1. SEX <b>Female</b>		4. RACE <b>Col 2</b>		5. DATE OF BIRTH <b>7-10-77</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>6</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7. DATE PRONOUNCED DEAD <b>3/21/84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
11. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baby</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>907 Seagull Ave. 21225</b>			
14. FATHER'S NAME FIRST <b>Wayne</b> MIDDLE <b>Brooklyn</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Vera</b> MIDDLE <b>Harris</b> LAST <b>HARRIS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Miss Vera Harris 907 Seagull Ave 21225</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>6:15</b> MONTH <b>3</b> DAY <b>19</b> YEAR <b>84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by auto</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET <b>900 N. Fulton St.,</b> CITY OR TOWN <b>Balto. City,</b> COUNTY <b>Md.</b> STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>GRK</b>				TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>3/21/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE <b>3-26-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>				23d. LOCATION CITY OR TOWN <b>Brooklyn A.A.C., Md.</b> STATE			
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave</b>				25a. DATE RECD. BY REGISTRAR <b>27 1984</b>				25. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Earl W. Harris, Sr.										2a. DATE KNOWN OF DEATH ESTIMATED XX MONTH DAY YEAR 2-29 19 84		2b. HOUR 8:57 a. m			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11-30-46		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 2-29 19 84		2d. HOUR 8:57 a. m			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, md.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER				12b. KIND OF BUSINESS OR INDUSTRY Amtrak	
13a. STATE md				13b. COUNTY BALTO				13c. CITY OR TOWN BALTO				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3917 STOKES DR.			
14. FATHER'S NAME FIRST MIDDLE LAST MELVIN H. HARRIS								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCILLE BUSHRD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 212-46-1256				17. INFORMANT CAROLYN HARRIS S/A									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 2-29-84									
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-5-84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest				23d. LOCATION CITY OR TOWN COUNTY STATE Garrison md.							
24. FUNERAL DIRECTOR NAME Brown-Thompson				ADDRESS 1913 W. BALTO. ST.				25a. DATE REC'D. BY REGISTRAR MAR 06 1984				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION



2

NO 10 1138K

11/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 6 9 6 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES Z. HARRIS			2a. DATE OF DEATH MONTH DAY YEAR SAT. MAR. 3, 1984			2b. HOUR MIN. 9:30 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 25, 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 83		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
11. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3601 FORDS LANE APT. 716				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3601 FORDS LANE APT. 716 (21215)			
14. FATHER'S NAME FIRST MIDDLE LAST MOSES ZELICOVITZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-52-6730		17. INFORMANT ADDRESS Dr. S. Elliott Harris 8200 Symphony Dr. (21208)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Cancer</u> 4850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>78</u> , to <u>Mar.</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Mar. 2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M. D.</u> S. ELLIOTT HARRIS						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS 8100 HARTFORD RD.			
23a. BURIAL, CREMATION, REMOVAL 15 SPECIES BURIAL			23b. DATE 3/4/84		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)						25a. DATE REC'D. BY REGISTRAR MAR 9 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP

BOOK

1956

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1956

1956

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

06762

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George Harris</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3-2-84</b>		2b. HOUR <b>11:50</b> M
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 29 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lafayette Square Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Reserve Bank</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elbert Harris</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>212-22- 6416</b>		17. INFORMANT ADDRESS <b>5813 Townbrook Drive</b> <b>George E. Harris Jr. Baltimore, Md. 21207</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4279 Cardiac arrhythmia**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **2 CVA**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **3 COBS**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**(4) Old pulmonary tuberculosis**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> 19 <b>82</b> , to <b>3/2</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/28</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Moges Gebremanan</b>		22c. DATE SIGNED <b>3/2/84</b>	22d. ADDRESS <b>Arbutus Memorial Park</b>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Moges Gebremanan</b>		22f. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/7/1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>NUTTER + SONS FUNERAL HOME INC.</b> ADDRESS <b>2501 GWYNNS FALLS PKWY. 21216</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 8 1984</b>	25b. REGISTRAR'S SIGNATURE <b>Dr. Richard Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy retained.

BP

Burial 3/7/1964 Arctus Memorial Park Baltimore, Maryland



Handwritten notes and signatures, including a large 'X' and various illegible scribbles.

Extensive handwritten notes and signatures in the middle section of the page, including a large 'X' and various illegible scribbles.

No.	212-22-8416	George E. Harris Jr.	Baltimore, Md. 21207	8813 Towneck Drive	Hd
Elbert	Harris	Ellen			
Maryland	Baltimore	X	Baltimore, Maryland 21218	1923 Kennedy Avenue	Reserve Bank
Baltimore	Lafayette 2 care Nursing Home	Maintenance			Federal
Maryland	U. S. A.	X	LaBaltimore City		
Male	Black	29 1902	21		

Handwritten notes and signatures at the top of the page, including a large 'X' and various illegible scribbles.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06763

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>James Alfred Harris</i>			2a. DATE OF DEATH MONTH <i>3</i> DAY <i>1</i> YEAR <i>1984</i>		2b. HOUR M
3. SEX <i>MALE</i>	4. RACE <i>CAUCASIAN</i>	5. DATE OF BIRTH MONTH <i>12</i> DAY <i>29</i> YEAR <i>1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>INDIANA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Key Circle Hospice</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Carpenter</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1213 Eutaw Place 21217</i>
14. FATHER'S NAME FIRST <i>Unknown</i> MIDDLE <i>Unknown</i> LAST <i>Unknown</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Jacqueline</i> MIDDLE <i>Cox</i> LAST <i>1213 Eutaw Pl</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unknown</i>		16b. SOCIAL SECURITY NO. <i>579-05 4783</i>		17. INFORMANT <i>Jacqueline Cox</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CAR DISEASE Arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>518 CVA</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION <i>3-7-84</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CVA</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-21-84</i> 19 to <i>1-21-84</i> 19, that (I) (we) last saw the deceased alive on <i>1-21-84</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A. J. Miller</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>2-10-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AJASA JIDHU</i>		22e. ADDRESS <i>5216 Lyngate Rd. Glen Ridge NJ</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-7-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cem.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landownes A.A. Md.</i>		24. FUNERAL DIRECTOR NAME <i>Charles A. Rice</i> ADDRESS <i>FSPA 1300 Eutaw Place</i>			
25a. DATE REC'D. BY REGISTRAR <i>MAR 14 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "terminal disease," the medical examiner must be notified of age.

1945-1946 (approx.)

1945

1946

1947

1948

1949-1950 (approx.)



RELEASED AS NON MED BY DR KAUFFMAN OF MEDICAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified.

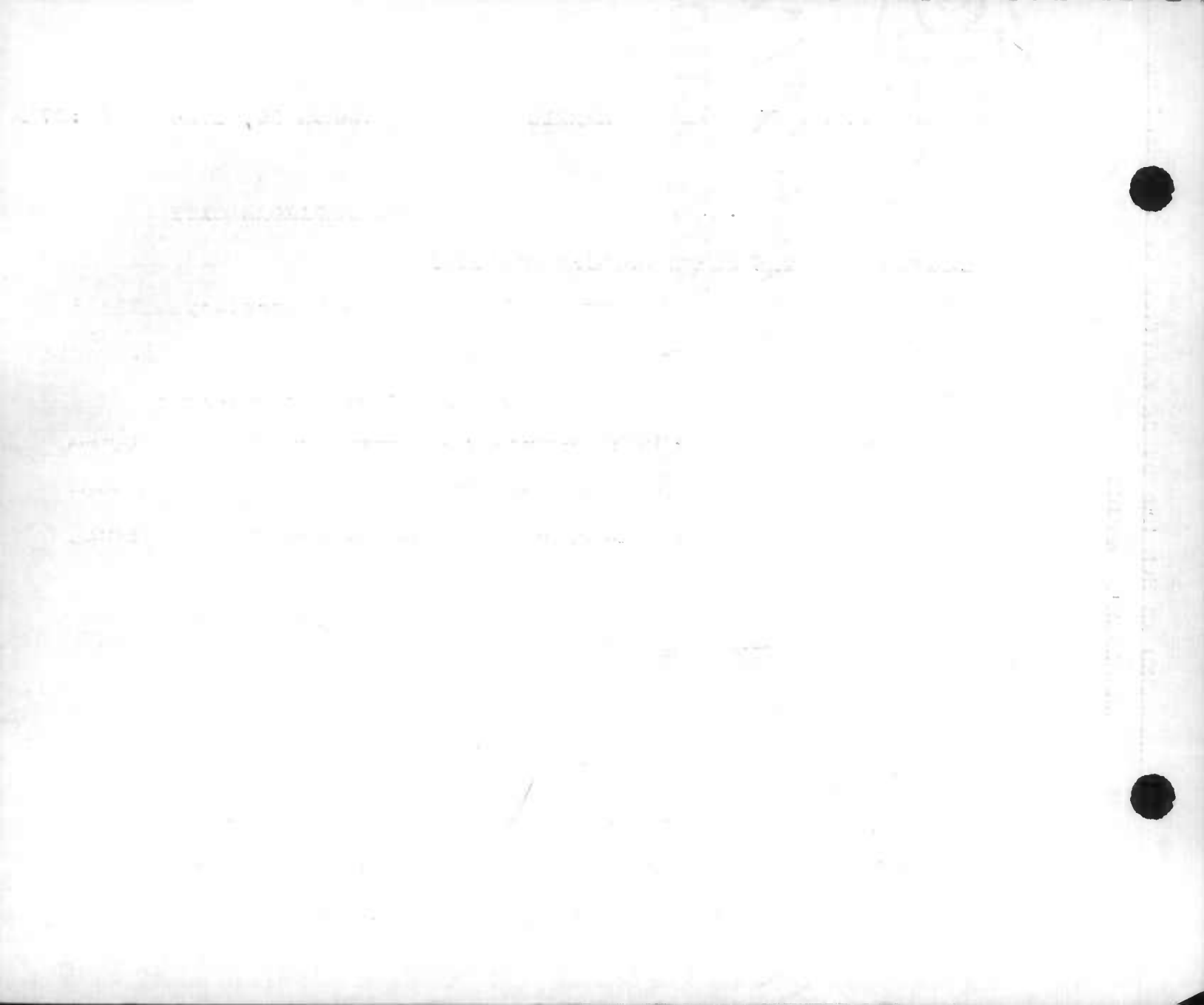
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06764

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JIM (JAMES) HARRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 30, 1984</b>			2b. HOUR <b>09:07AM</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 10 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>56</b>		7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1037 Broadway 21205</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pearly Harris</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Fitzgerld</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>230-28-4916</b>		17. INFORMANT ADDRESS <b>Gladys Bolden 1037 Broadway</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR ASYSTOLE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHERO SCLEROTIC HEART DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b> <b>1 hour</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>8:20 AM 3/30, 19 84</b> , to <b>9:07 AM 3/30, 19 84</b> , that (1) (we) lost saw the deceased alive on <b>3/30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas J. Chambers</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/30/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS J CHAMBERS</b>						22e. ADDRESS <b>JOHNS HOPKINS HOPKINS</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>4/4/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc, 1101 E. North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 & 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 6 7 6 5  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH ESTIMATED				2b. HOUR			
Macie Harris				XX MONTH DAY YEAR 3-6 19 84				M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD				7d. HOUR	
Female	Black	4/27/1915	68 YRS.			3-6 19 84				3:27 P.M.	
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					MD.
B. Carolina		U.S.A.				Baltimore City,					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		1603 Spray Court, Apt. 1				Housewife					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS					
Md.			Baltimore			1603 Spray Ct. 7					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
				Annie McBrine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		214-26-3635		Edward E. Harris - 1603 Spray Ct.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 3-7-84			
EXAMINER'S NAME (OR PRINT)				ADDRESS							
Dennis F. Smyth, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Buried		3/12/84		Mt. Auburn C.		Baltimore Md.					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. J. Gurnell 1712-14 W. North				MAR 13 1984		Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signed, any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARRY</b> <b>HARRIS</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>8</b> YEAR <b>84</b> 2b. HOUR <b>825 P.M.</b>		
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>18</b> YEAR <b>95</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Sidney</b> MIDDLE <b>B.</b> LAST <b>Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE <b>Barnes</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-36-6646</b>		17. INFORMANT <b>Hilda Harris</b> ADDRESS <b>2632 Oswego Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>uremia from renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>sepsis from decubitus ulcers</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.					
23a. SIGNATURE <b>Victor A. Nowk</b> DEGREE <b>M.D.</b>				23b. DATE SIGNED <b>3/8/84</b>	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VICTOR. A. NOWK</b>		23d. ADDRESS <b>SINAI HOSPITAL OF BALT.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>3/12/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H, Inc</b> ADDRESS <b>1101 E. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1984</b> 25b. REGISTRAR'S SIGNATURE <b>G. Davidson-Randall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified orally.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06961	
1. DECEASED NAME (TYPE OR PRINT) <b>Phillip Powell Harris</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>March 5, 1984</b>			2b. HOUR <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 9 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3200 Carlisle Ave. 21216</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician, Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dpt of Army</b>			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>3200 Carlisle Ave. 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jerome Maith</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Chapman Harris</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>		17. INFORMANT <b>Edith F. Harris</b>		ADDRESS <b>3200 Carlisle Ave. 21216</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiomyopathy</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypertensive Heart Disease</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-11-</b> 19 <b>82</b> , to <b>1-10-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>1-10-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Larry S. Perry M.D.</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-7-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Larry S. Perry M.D.</b>						22e. ADDRESS <b>107 E. Saratoga St. Suite 102 Baltimore, Md. 21202</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/12/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veterans Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Nutter &amp; Sons Funeral Home Inc.</b>						24a. DATE REC'D. BY REGISTRAR <b>MAR 7 1984</b>		24b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			
25. ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND HARRIS</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>25</b> YEAR <b>84</b>		2b. HOUR <b>6:45 A</b>
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>31</b> YEAR <b>1946</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> city MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coppin State College</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Willie</b> MIDDLE <b>B.</b> LAST <b>Harris Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b> MIDDLE <b>L.</b> LAST <b>Ratliff</b>		13e. STREET ADDRESS / ZIP CODE <b>1904 Mt. Royal Terrace Baltimore, Md. 21217</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>218-44-8115</b>		17. INFORMANT ADDRESS <b>Jo Anne B. Harris Baltimore, Maryland 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4280</b> IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ANASARCA, OBESITY</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-15</b> , 19 <b>84</b> , to <b>3-25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3-25-84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Krishan M. Mathur</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/25/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHAN M. MATHUR</b>				22e. ADDRESS <b>2600 Liberty Hts Baltimore Md. 21215</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/30/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Anne Arundel Co.</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Nutter &amp; Sons Funeral Home Inc.</b> NAME <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>	



State	City	U. S. A.	Address	Occupation	Age
Virginia	Richmond		Richmond Hospital	Teacher	38
Virginia	Baltimore	X	Baltimore, Maryland	State College	38
Illinois	Chicago		Chicago, Illinois	State College	38
Illinois	Chicago		Chicago, Illinois	State College	38

2501 Wynne Falls Hwy. Baltimore, Md. 21218  
Mt. Calvary Cemetery  
Anne Arundel Co. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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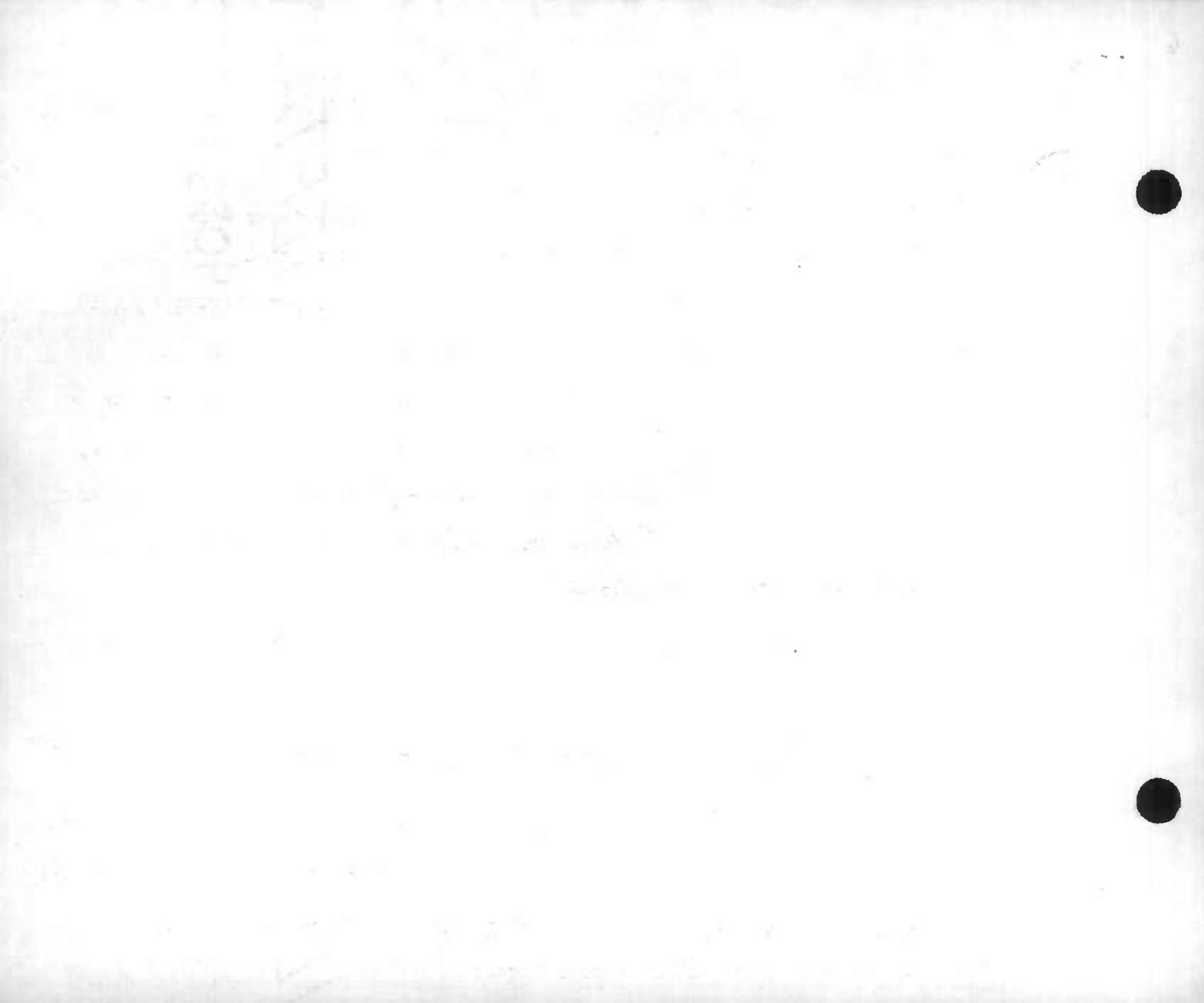
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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT A. HARRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/9/84</b>		2b. HOUR <b>10:45 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 29 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>78</b>	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bedford Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11 W. 20th Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Beth. Steel</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>11 W. 20th Street 21218</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen Harris</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Harris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217 01 2793</b>		17. INFORMANT ADDRESS <b>Mrs. Lucille Harris 11 W. 20th Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Cardiac-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Dis-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>brief</b> <b>brief</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension, Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 18</b> , 19 <b>72</b> , to <b>Mar 9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Mar 1</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edward F. Cotter</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>13 Mar 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD F. COTTER</b>		22e. ADDRESS <b>1900 E. NORTHERN PKWY. BALTO. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/15/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James A. Morton &amp; Sons</b>		ADDRESS <b>1701 Laurens Street</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jeha Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST NELLE	MIDDLE K.	LAST HARRISON	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
							MARCH 13, 1984	3:05 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR		8 2 1911		6. AGE (IN YEARS LAST BIRTHDAY)	72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail-Esskay		12b. KIND OF BUSINESS OR INDUSTRY Meat Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2820 E. Monument Street
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Woodby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-14-3110		17. INFORMANT ADDRESS Nellie Ruth Lagana Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ESCHERICHIA COLI BACTEREMIA, RIGHT LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RESPIRATORY FAILURE</u> PNEUMONIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>February 7, 1984</u> , to <u>March 13, 1984</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Mukesh Luhar</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUKESH LUHAR, M.D.				22e. ADDRESS CHURCH HOSPITAL 100 NORTH BROADWAY, BALTO., MD. 21231				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3/17/1984		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR MAR 16 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>		

MEDICAL CERTIFICATION



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 4/18/84 mtb F#590

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST ROBERT			MIDDLE C.			LAST HARRISON			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-17-84			2b. HOUR M 7:43A				
1. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 15 /1947		6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 3-17-84			7d. HOUR 7:43A				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4600 blk. Reisterstown Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian				12b. KIND OF BUSINESS OR INDUSTRY Pratt Library							
13a. STATE Maryland				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4826 Cordelia Avenue Baltimore, Maryland 21215			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Courtney Harrison								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Briscoe											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-50-3621				17. INFORMANT ADDRESS Lester R. Dennis Baltimore, Md. 21215											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injuries</u> 9682 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject struck on head											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) open field				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4600blk Reisterstown Rd. Baltimore, Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER								DATE SIGNED 3-17-84							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/23/1984		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME ADDRESS Nutter & Sons Funeral Home Inc. 2501 Gwynns Fall Pkwy. Baltimore, Md. 21216										25a. DATE REC'D. BY REGISTRAR MAR 20 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

Male Black B 18 April 21

U. S. A.

1035 Connelley Ave  
Baltimore, Maryland 21215

1035 Connelley Ave  
Baltimore, Maryland 21215  
No. 1035-30-3021

1035 Connelley Ave  
Baltimore, Maryland 21215  
1035 Connelley Ave  
Baltimore, Maryland 21215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				06972 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET HART</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 23 1984</b>				2b. HOUR <b>4:09 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 23, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital Corporation</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waitress</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>		
13a. STATE <b>Md.</b>				13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>311 S. Wolfe St. #21231</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred --- Buckheit</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary --- Reynolds</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No ---</b>				16b. SOCIAL SECURITY NO. <b>215-01-5152</b>		17. INFORMANT ADDRESS <b>Angela Pratt - 311 S. Wolfe St. #21231</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCKS</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>POSSIBLE PNEUMONIA</b> <b>ACUTE RENAL FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>MARCH 14, 1984</b> to <b>MARCH 23, 1984</b> that (1) (we) last saw the deceased alive on <b>MARCH 23, 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Mukesh Luhar</b>				DEGREE <b>MD</b>				ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MUKESH LUHAR, MD</b>				22e. ADDRESS <b>CHURCH HOSPITAL 100 N. BROADWAY</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/27/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>George A. Weber &amp; Sons, Inc. - 705 S. Ann St.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson Handell</b>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
GRACE E. HARVEY		3 29 84		11:36 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	MONTH DAY YEAR	70	Baltimore City	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Baltimore City Hospitals		Housewife		
13a. STATE		13b. CITY OR TOWN	13c. CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1101 63rd Street 21237	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		17. INFORMANT ADDRESS	
Charles H. Shaffer		Maude E. Ebaugh		Doris M. Getz 401 Avery Court Joppa, Md.	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. DATE OF OPERATION	
No		218-09-5379		19. DATE OF OPERATION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest					
4100					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Myocardial Infarct					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Ischemic Heart Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
COPD; Hyperglycemia; Hypertension					
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21. LOCATION	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		CITY OR TOWN COUNTY STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 28, 1984, to March 29, 1984, that (I) (we) last saw the deceased alive on March 29, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Robert E. Fisher		M.D.		3/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Robert E. Fisher		4940 Eastern Avenue, Baltimore, MD 21204			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		April 2, 1984		LakeView Memorial Park	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		APR 3 1984		Davidson-Rendall	
Leonard J. Ruck, Inc. Baltimore, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRIETTA HARVEY			2a. DATE OF DEATH MONTH DAY YEAR 3 16 84			2b. HOUR 48 M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 17 99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN CATOW MAJOR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Lion Bros. Co.		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 529 Lucia Avenue 21229		
14. FATHER'S NAME FIRST MIDDLE LAST John L. Green			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Halioran							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-14-3328		17. INFORMANT John T. Harvey				ADDRESS 409 4th Ave. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arrest Osteosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/16 19 84, to 3/16 19 84, that (I) (we) lost saw the deceased alive on 3/16 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Herbert J. Levickas MD						DEGREE MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Herbert J. Levickas						22e. ADDRESS 5404 East Drive 21227				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/20/84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229						25a. DATE REC'D. BY REGISTRAR MAR 21 1984		25b. REGISTRAR'S SIGNATURE		

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (Type in full) FIRST MIDDLE LAST <b>MARY M NARVEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 / 13 / 84</b>			2b. HOUR MIN. <b>12:30 P</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 17 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housework</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>- - -</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Sinkfield</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-20-6382</b>		17. INFORMANT ADDRESS <b>Wendell Sinkfield 6602 Wycomb Way</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CardioRespiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 mins</b>	
5150 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Progressive Hypoxia/Hypotension</b>		24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Progressive Pulmonary Fibrosis</b>		5 yrs	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>84</b> , to <b>3/13</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Cheryl Newman</b>				DEGREE <b>CL NEWMAN</b>		22c. DATE SIGNED <b>3/13/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CL NEWMAN</b>				22e. ADDRESS <b>JOHNS HOPKINS Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/16/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson,</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc, 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1984</b>			

3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

D-6976

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM N. HAUGH			2a. DATE OF DEATH MONTH DAY YEAR MARCH 11, 1984			2b. HOUR 1201 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - Typewriter Company	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST C. Albert Haugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alta (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 12 8714		17. INFORMANT ADDRESS Morgan L. Amaimo, Balto., MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 2989 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Aspirations</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Dementia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>status post cerebrovascular accidents</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>84</u> , to <u>3-11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Markus ms</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-11-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Markus				22e. ADDRESS BCH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/14/84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD				25a. DATE REC'D. BY REGISTRAR MAR 14 1984			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1984 July 14

Henry W. Jackson & Son Co.

4800 York Road, Baltimore, MD 21212

Private

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06977

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Emily Faith Havlicsek</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/14/84</b>			2b. HOUR <b>3:00 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 13 84</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>18</b>		IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>					13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bruce</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Teresa Susan Wolley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Bruce Havlicsek 214 Highmeadow Rd. Reisterstown Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**7690**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

**for Embolism in cerebral system**  
**Mechanical Ventilation**  
**RDS (pneumonia) or pneumonia**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**< 1 hr****18 Hrs**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**Prematurity 29-31 weeks gestation**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **3-13-84** to **3-14-84**, that (I) (we) lost  
saw the deceased alive on **3-14-84**, and that (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (If (we) did not view the body after death, so state.)

23a. SIGNATURE <b>Jacob K. Felix</b>		23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jacob K. Felix</b>		23c. ADDRESS <b>Sinai</b>		23d. DATE SIGNED <b>3-14-84</b>	
23e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		23f. MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		23g. DATE REC'D. BY REGISTRAR		23h. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

23a. BURIAL (CREMATION) REMOVAL (SPECIFY) <b>cremation</b>		23b. DATE <b>Mar 22, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>H. J. Eckhardt</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		25c. ADDRESS <b>11605 Reisterstown Rd. 21117</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Printed by 24-31-1914  
RDS (Printed) 24-31-1914

24-31-1914

24-31-1914



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06978

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LINWOOD Arthur HAWKINS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3-19-84</b>	
3. SEX <b>Male</b>		2b. HOUR <b>4:15 PM</b>	
4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 7 34</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Md. Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	
13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1623 W. LANVALE 21217</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVIS Hawkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vera Toney</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>219-30-3942</b>	
17. INFORMANT ADDRESS <b>Mary Rich 908 N. Monroe ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>LLANES MD</b>		22c. DATE SIGNED <b>3-19-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LLANES</b>		22e. ADDRESS <b>UNIV. OF MD HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-23-84</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James A. MORTON + SONS</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b>	
ADDRESS <b>1701 LAURENS</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FILED

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Handwritten notes and signatures, including "Davis" and "H. L. Davis".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked under (a), it shows pay injury, or other traumatic event, the medical examiner must make a ruling on the cause of death.

item 6 #G590 4/4/84 ph  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06979

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FANNIE</b>			FIRST <b>R.</b>			MIDDLE <b>HAYES</b>			LAST			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>28</b> YEAR <b>84</b>			2b. HOUR <b>7<sup>30</sup></b> M														
3. SEX <b>Female</b>			4. RACE <b>Black</b>			5. DATE OF BIRTH MONTH <b>7</b> DAY <b>14</b> YEAR <b>01</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS			IF UNDER 1 YEAR MONTHS <b>82</b> DAYS <b>82</b>			IF UNDER 24 HRS HOURS <b>82</b> MIN.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.																				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Deaton Medical Center</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>1114 Arunah Ave. Baltimore, Maryland 21228</b>														
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Washington Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Muir</b> LAST <b>Muir</b>						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>						16b. SOCIAL SECURITY NO. <b>215-16-6267D</b>						17. INFORMANT <b>Shirley Diggs</b> ADDRESS <b>1114 Arunah Avenue Baltimore, Maryland 21228</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>7070</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Decubitus Ulcers</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>														
															<b>2 days</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ORGANIC BRAIN SYNDROME WITH CONTRACTURES</b>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/5</b> 19 <b>84</b> , to <b>3/28</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/28</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>Harry S. Strothers</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>3/29/84</b>																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARRY S. STROTHERS MD</b>						22e. ADDRESS <b>611 S. Charles St 21230</b>																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/2/1984</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE																				
24. FUNERAL DIRECTOR <b>Nutter &amp; Sons Funeral Home Inc.</b> NAME ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>												25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>														

BP



Baltimore City

U. S. A.

Maryland

John Deaton Medical Center

Baltimore

Homemaker

Home

1111 Arman Ave.

Baltimore, Maryland 21228

Baltimore

Maryland

Washington St. N.W.

William

Mail

111 Arman Avenue

212-15-6270 Shirley Dicks Baltimore, Maryland 21228

No.

Baltimore, Maryland

1/2/1980 Philip A. Rinaldi

2501 Gwynns Falls Pkwy. Baltimore, Md. 21216  
Victor & Sons, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE J. HEACOCK			2a. DATE OF DEATH MONTH DAY YEAR 3-8-84		2b. HOUR 12 <sup>45</sup> / <sub>A</sub> M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 23 23		
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Police		12b. KIND OF BUSINESS OR INDUSTRY B. Green & Co.		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Heacock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maunie Bramble		16. STREET ADDRESS / ZIP CODE 2520 Tolley Street 21230		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 215-16-0379		17. INFORMANT ADDRESS Betty L. Heacock 2520 Tolley St. 21230		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POSS PULMONARY EMBOLUS</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>RECENT MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE D. Shamsuddin		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/08/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SHAMSUDDIN		22e. ADDRESS Bon Secours Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/12/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		
23d. LOCATION CITY OR TOWN Elkridge		COUNTY Howard		STATE Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR MAR 9 1984		

45



Belmont

Belmont

Special Agent in Charge

Special Agent in Charge

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Belmont

Mr. Belmont

Mr. Belmont

Mr. Belmont

Mr. Belmont

Mr. Tolson, Mr. Belmont, Mr. Mohr, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. DeLoach, Mr. Evans, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

Mr. Tolson, Mr. Belmont, Mr. Mohr, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. DeLoach, Mr. Evans, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

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Mr. Tolson

Mr. Tolson

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CHESTER L. HEADLEY</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>3 8 1984</b>		2b. HOUR <b>9:04 P M</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 29, 1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>3 8 1984</b>		2d. HOUR <b>9:04 P M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electric Engineer-Balt.G.&amp;E. Co</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>105 Fairfield Drive 21228</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas W. Headley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Walker</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>212-05-6536</b>		17. INFORMANT <b>P.O. Box 193 Barbara Forrest -Reedville, Va. 22539</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> <b>8120</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>3:30 P.M.</b> MONTH DAY YEAR <b>3-8-1984</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/tractor trailer collision.</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>York Rd. &amp; 695 Balto. Md.</b>						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER					DATE SIGNED <b>3-9-84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>March 13, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Coan Baptist Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Heathville Virginia</b>				
24. FUNERAL DIRECTOR <b>Leory M. &amp; Russell C. Witzke Funeral Homes P.A.</b>			1630 Edmondson Avenue, Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				



May 29, 1968

W.L.A.

Executive Committee

1968-1969

1968-1969

1968-1969

ORDER

1968-1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18, always any injury, or other traumatic event, the official examiner must investigate the cause of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD JOSEPH HEBRANK</b> <b>EDWARD J. HEBRANK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3 27 84</b> 2b. HOUR <b>4:49</b> AM			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 20, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1521 E. Northern Parkway 21239</b>		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-01-5254</b>		17. INFORMANT <b>Edward G. Hebrank</b>		ADDRESS <b>601 Starkey Rd. #84 Key Largo, Fla. 33541</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE PULM. DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>11 days</b> <b>20 years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>upper GI bleeding, renal failure</b>							
19a. DATE OF OPERATION <b>3/7/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>G.I. Bleeding</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>2/22/84</b> 19____, to <b>3/27/84</b> 19____, that (I) (we) last saw the deceased alive on <b>3/27/84</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Gregory P. Harris</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/27/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY P. HARRIS</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSP. BALTO. MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/30/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

BP

1. Conduct 2. Attitude 3. Character

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH M. HECK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3 01 84</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 28, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS / ZIP CODE <b>701 Deepdene Road 21210</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John - Karmann</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna E. Weber</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-26-3080</b>		17. INFORMANT ADDRESS <b>Miss Nina Heck Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>7070</b> IMMEDIATE CAUSE (a) <b>Dental infection</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital)) attended the deceased from <b>31 19 84</b> , to <b>31 19 84</b> , that (I (we)) last saw the deceased alive on <b>31 19 84</b> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)							
22b. SIGNATURE <b>Ira H. Copeland</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <b>3/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRA H. COPELAND M.D.</b>				22e. ADDRESS <b>201 EAST UNIVERSITY PARKWAY</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar 3, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 2 1984</b> <b>Heard</b>			

11/25/64

1

RECEIVED

ELIZABETH

BALTIMORE CITY

THE UNION MEMORIAL HOSPITAL

BALTIMORE

301 EAST UNIVERSITY PARKWAY

IRA H. GORDON M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B2  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ARCHIE W. HEDGE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 1, 1984			2b. HOUR 10:30 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 14 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 101 Center Place 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest G. Hedge			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-09-7378	
17. INFORMANT ADDRESS 8044 Wallace Road Balto., MD. 21222			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG WITH METASTASIS 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 7, 19 84, to MARCH 1, 19 84, that (I) (we) last saw the deceased alive on MARCH 1, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (or that I did not view the body after death).										
22b. SIGNATURE <i>Walker Impaglatelli</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER IMPAGLIATELLI, M.D.						22e. ADDRESS CHURCH HOSPITAL 100 NORTH BROADWAY, BALTIMORE, MD 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/5/1984		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR MAR 6 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

1911  
Duda-Ruck, T.  
MAR 6 1911  
WILLIAM DUDA  
1911



20% COPIES  
THE UNIVERSITY OF CHICAGO



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 6 9 8 5

210A

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME

(TYPE OR PRINT)

FIRST MIDDLE LAST  
HARRY M. HEIM

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

3 3 84

M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

6 4 07

6. AGE (IN YEARS LAST BIRTHDAY)

76

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

City Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Mill Plant

12b. KIND OF BUSINESS OR INDUSTRY

Amer. Copper-

ridge &amp; Steel

Drum Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

2713 Gray Manor Terrace

14. FATHER'S NAME

FIRST MIDDLE LAST  
Michael Heim

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Eleanore Nagle

21222

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

215-09-4291

17. INFORMANT

2713 Gray Manor Ter. Balto., Md. 21222

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4280

DUE TO, OR AS A CONSEQUENCE OF

(b) Kidney Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) CHF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

now the deceased arose on

above, (I) (we) (did) (did not) view the body after death.

3-3-84 2 84 3-3 84

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

3-3-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

GUTHRIE

22e. ADDRESS

Bilt City Hosp.

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

3-6-84

23c. NAME OF CEMETERY OR CREMATORY

Meadowridge M. P.

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

STATE Maryland

24. FUNERAL DIRECTOR

Lassahn Funeral Home

7401 Belair Rd.

Balto., Md. 21236

25. DECEASED'S

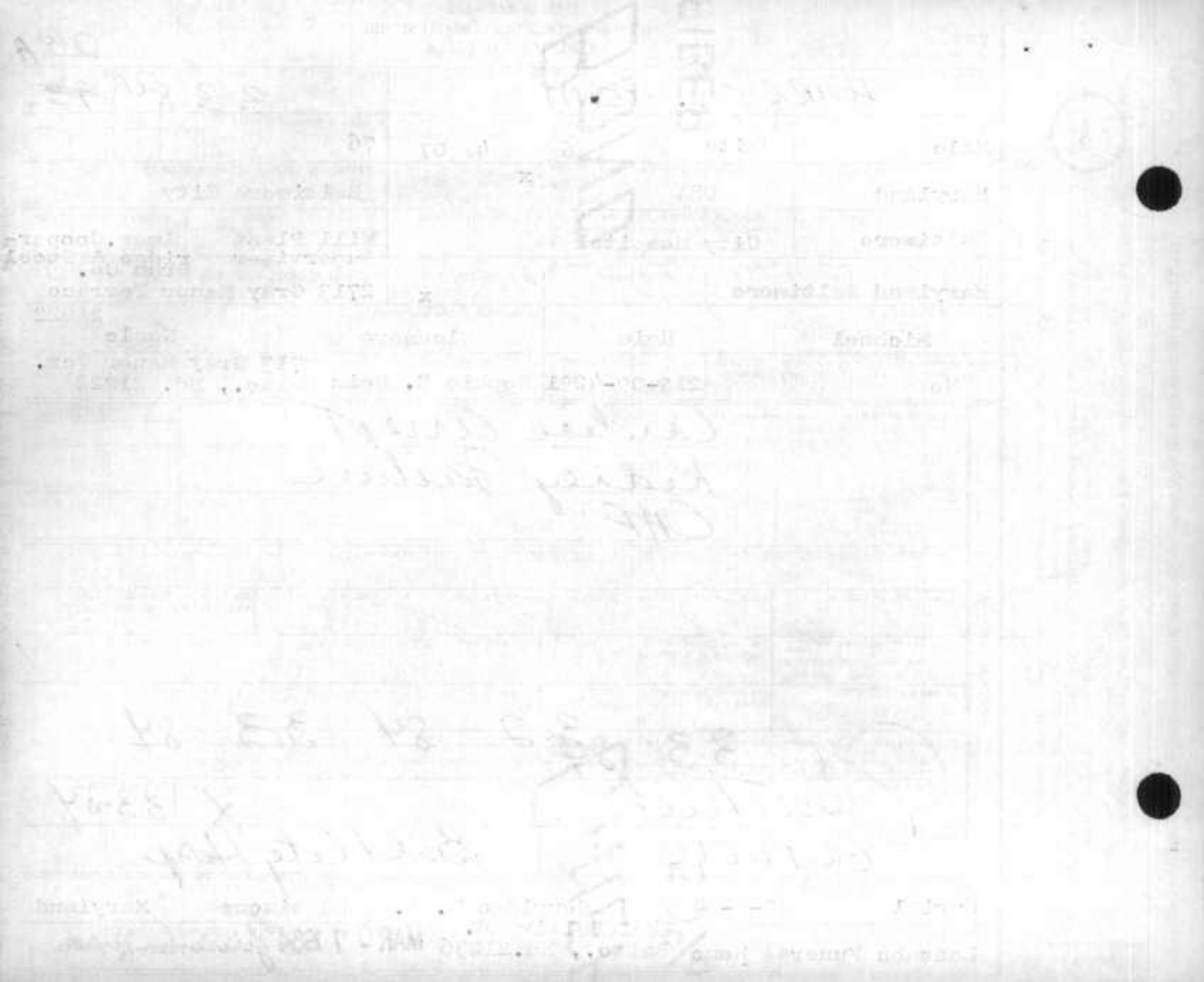
MAR 7 1984

REGISTRAR'S SIGNATURE

John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with #12 form after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician who has been designated as a medical examiner retained by the hospital or attending physician. The law requires that the death certificate be executed by a physician who has been designated as a medical examiner retained by the hospital or attending physician. The law requires that the death certificate be executed by a physician who has been designated as a medical examiner retained by the hospital or attending physician.

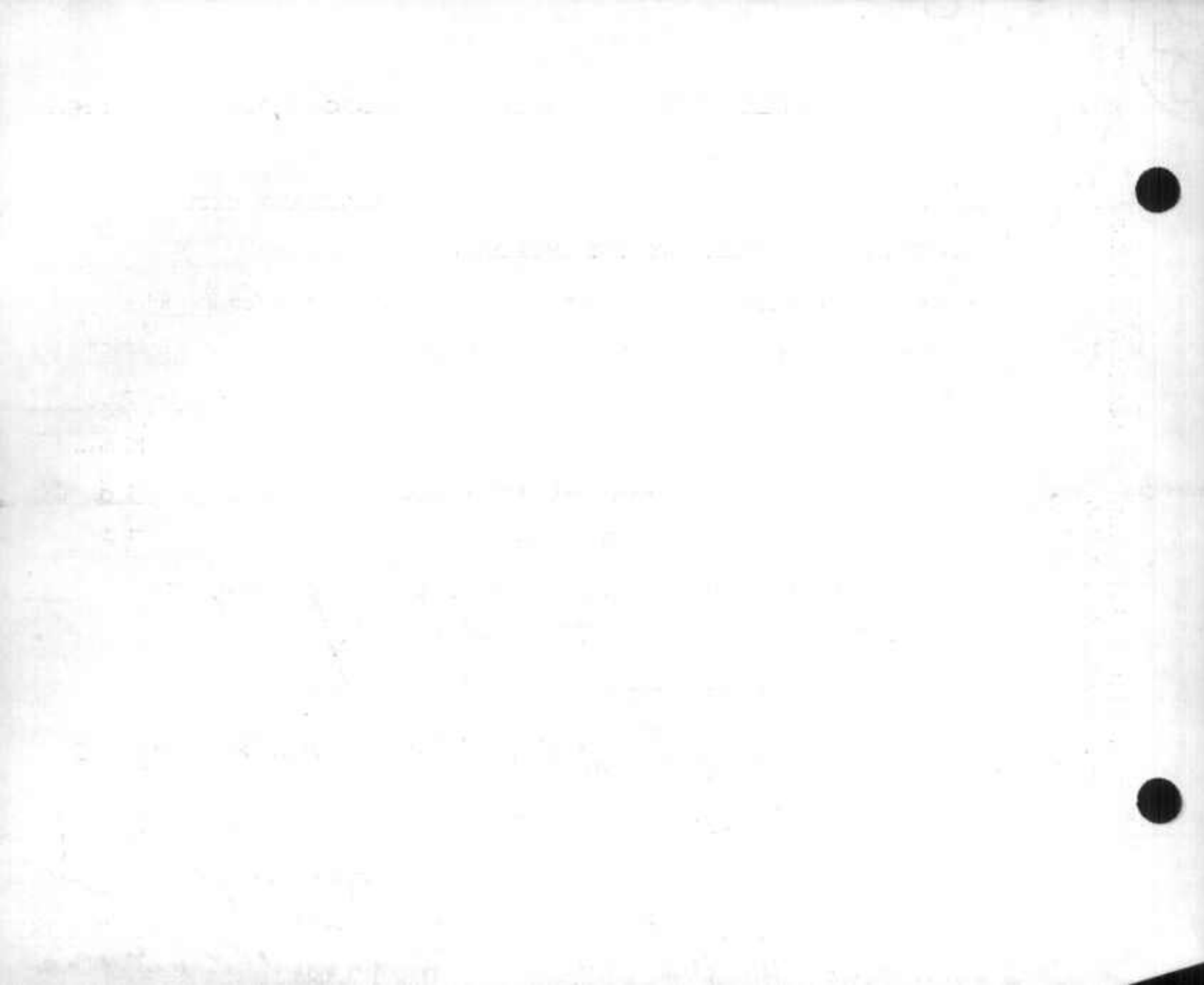
TO FUNERAL DIRECTOR: DR. ATTE MARGARET KORELLE, attending physician and certified, filled in and signed by the physician. The death certificate should be detached for use as the burial permit. Then the physician should sign the death certificate and the funeral director should sign the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. FOR STATE REGISTRAR 4-3-84 cn					Item 21a thru 22a				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTORIA HEIN					2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1984				
3. SEX Female					2b. HOUR 6:28A <sup>M</sup>				
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13108 Brandon Way Rd. 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Adelbert T.X. Emerson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys - Herrick				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 085-12-3826		17. INFORMANT ADDRESS Richard P. Hein 13108 Brandon Way Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> 4589 DUE TO, OR AS A CONSEQUENCE OF (b) <u>subdural hematoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>trauma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 4 d 4 d	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>metastatic adenocarcinoma of unknown primary</u>									
19a. DATE OF OPERATION 3-3-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute and Chronic <u>Evacuation of</u> <u>subdural</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30 P.M. 3-3-84 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fall Out of Bed			21d. LOCATION CITY OR TOWN COUNTY STATE JOHNS HOPKINS HOSP. 600 N. Wolfe St Baltimore City Md 21205		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) JOHNS HOPKINS HOSP.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 600 N. Wolfe St Baltimore City Md 21205			22a. I certify that (1) (this hospital) attended the deceased from <u>Mar 1</u> , 19 <u>84</u> , to <u>Mar 6</u> , 19 <u>84</u> , that (I/we) saw the deceased alive on <u>Mar 6</u> , 19 <u>84</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death. <u>Natural</u>		
22b. SIGNATURE <u>R Lange</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/6/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R LANGE MD		22e. ADDRESS The Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial, Removal		23b. DATE 3/9/1984		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sidney, New York			
24. FUNERAL DIRECTOR NAME Jerry Elmer, Hampstead				25a. DATE REC'D. BY REGISTRAR MAR 12 1984		25b. REGISTRAR'S SIGNATURE L. A. Davidson-Randall			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06987

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Winifred B. Heisner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-16-84</b>		2b. HOUR <b>8:22 PM</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 29 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public Service</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4323 Sheldon Avenue 21206</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Byrnes</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Roche</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-38-0479</b>			17. INFORMANT ADDRESS <b>John E. Heisner, Jr., 662 Bay Green Drive Arnold, Md. 21012</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5570</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metabolic acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>extensive necrotic bowel</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <b>renal insufficiency</b>											
19a. DATE OF OPERATION <b>3-15-84</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>necrotic bowel</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 16</b> 19 <b>84</b> , to <b>March 16</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>March 16</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Henry Fooks, Jr. M.D.</b>						22c. DATE SIGNED <b>3-16-84</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry Fooks, Jr.</b>		
22e. ADDRESS <b>Union Memorial Hospital</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery Baltimore</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John D. ...</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either (b) shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 6 9 8 8  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL HEMPHILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-13-84</b>			2b. HOUR P <b>9:05 M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 9 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pipe Fitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Washington Hagerstown</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Hemphill</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Staubs</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>4860</b>		17. INFORMANT <b>Harold B. Hemphill 103 Glenrae</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b> <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Central Nervous System Vascular</b>									
19a. DATE OF OPERATION <b>Jan 13 1984</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>4860</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>600 N. WOLFE ST. 21205 MD.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 22 1984</b> to <b>Mar 13 1984</b> that (I) (we) last saw the deceased alive on <b>Mar 13 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R.A. Lange MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/13/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.A. LANGE MD</b>						22e. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-16-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich Hagerstown, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>MAP 10</b>		25b. REGISTRAR'S SIGNATURE <b>John K...</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper and file it in the file of the deceased. It should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death must be notified at post.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				6 9 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
GEORGE D. HENDERSON SR				MARCH 13, 1984		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		7 MONTH 24 DAY 03 YEAR		80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		2004 NORTH WOLFE STREET					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
Maryland				Baltimore		2004 N. Wolfe St. 21213	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Richard Henderson				FIRST MIDDLE LAST Martha Rowlett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				217-20-6015		Elizabeth Colbert 2004 N. Wolfe St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular</u> 1850 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic CA</u> (c) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 81, to 3/13, 19 84, that (I) (we) lost saw the deceased alive on 03/09 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)				22b. SIGNATURE DEGREE Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>		22c. DATE SIGNED 3/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Gregory Kelly MD				1000 E. Eager St. 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/17/84		Mount Calvary Cem.		Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc. 1101 E North Avenue				MAR 15 1984 [Signature]			

MEDICAL CERTIFICATION

2011-12-15

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10/10/11 10:10 AM 10/10/11 10:10 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
3. SEX					4. RACE		5. DATE OF BIRTH			6. AGE	
7a. BIRTHPLACE					7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION					12a. USUAL OCCUPATION	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					13e. STREET ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT				
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN HENDERSON</b>					2a. DATE OF DEATH MONTH <b>3</b> / DAY <b>30</b> / YEAR <b>84</b>					2b. HOUR <b>9:30</b> A.M.	
3. SEX <b>MALE</b>					4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>1</b> / DAY <b>20</b> / YEAR <b>08</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS. <b>75</b> MONTHS <b>7</b> DAYS <b>15</b> HOURS <b>15</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BART MD</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a. STATE <b>Md.</b>					13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					13e. STREET ADDRESS <b>5033 Chalgrove Ave.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>BW 11 470-09-9896</b>		17. INFORMANT <b>Ivory Henderson</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION; CVA</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>90 days</b> <b>YRS</b>					PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> 19 <b>84</b> to <b>3/30</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/29/84</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE <b>K. M. ZONIE</b> MD DEGREE					22c. DATE SIGNED <b>3/30/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth Zonie MD</b>					22e. ADDRESS <b>10807 FARM RD LUTHERVILLE MD</b>					22f. DATE REC'D. BY REGISTRAR <b>APR 4 1984</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>4/4/84</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Garrison For st</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Md</b>					23e. REGISTRAR'S SIGNATURE <b>Charles E. Anderson</b>						
24. FUNERAL DIRECTOR NAME <b>Chas E Anderson</b>					24b. ADDRESS <b>2700 Edmondson Ave</b>					24c. DATE REC'D. BY REGISTRAR <b>APR 4 1984</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a medical investigation conducted.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06991

FOR STATE REGISTRAR		William L		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST William Lynn Henderson				MONTH DAY YEAR March 23 84	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR Dec 8 94	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Pennsylvania		U.S.A.		89 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Keswick Home		Baltimore, City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Judge		St. of Md			
13a. STATE		13b. COUNTY		13c. STREET ADDRESS / ZIP CODE	
Maryland		A.A.		Bywater Road 21056	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Charles E. Henderson		FIRST MIDDLE LAST Ida M. Lynn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		W.W. I		Son	
		214.38.1879		Richard Henderson	
				ADDRESS Same as 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Respiratory Infection</u>					
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCV with Cerebral Thrombosis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>22 Feb</u> 19 <u>84</u> to <u>23 Mar</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>23 Jan</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Clayton B. Richardson M.D.</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED 23 MAR 1984	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Mar 23, 84		Security Process	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Catonsville Balto MD		MAR 27 1984		Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. DATE REC'D. BY REGISTRAR	
Singleton Funeral Home, Glen Burnie, MD					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK HENLEY</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>10</b> YEAR <b>84</b>			2b. HOUR <b>5:40</b> AM			
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>27</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>CITY BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>22 S. Rosedale St. 21223</b>	
4. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b></b> LAST <b>Henley</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elmira</b> MIDDLE <b></b> LAST <b>Wright</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>215102567</b>		17. INFORMANT ADDRESS <b>Leroy Brown 4002 Ayrdale Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>5130</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fung abscess</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic organic brain syndrome</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-9-84</b> 19 <b>83</b> , to <b>3-10-84</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3-9-84</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) sew the body after death.									
22b. SIGNATURE <b>Moges Gebremariam</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-10-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Moges Gebremariam</b>						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>3/16/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06793

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM MICHAEL HENNESSEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 13 84</b>		2b. HOUR <b>4:20 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 7, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC BALTIMORE, MARYLAND 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Empl.</b>

13a. STATE <b>Md.</b>			13b. COUNTY <b>----</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>138 N. Glover Street 21224.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew -- Hennessey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna -- Ritterbusch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 213 09 5675</b>		17. INFORMANT <b>Baltimore, Md. 21224</b> <b>Miss Anna H. Hennessey -138 N. Glover St.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIOPULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**TERMINAL CANCER**

DUE TO, OR AS A CONSEQUENCE OF

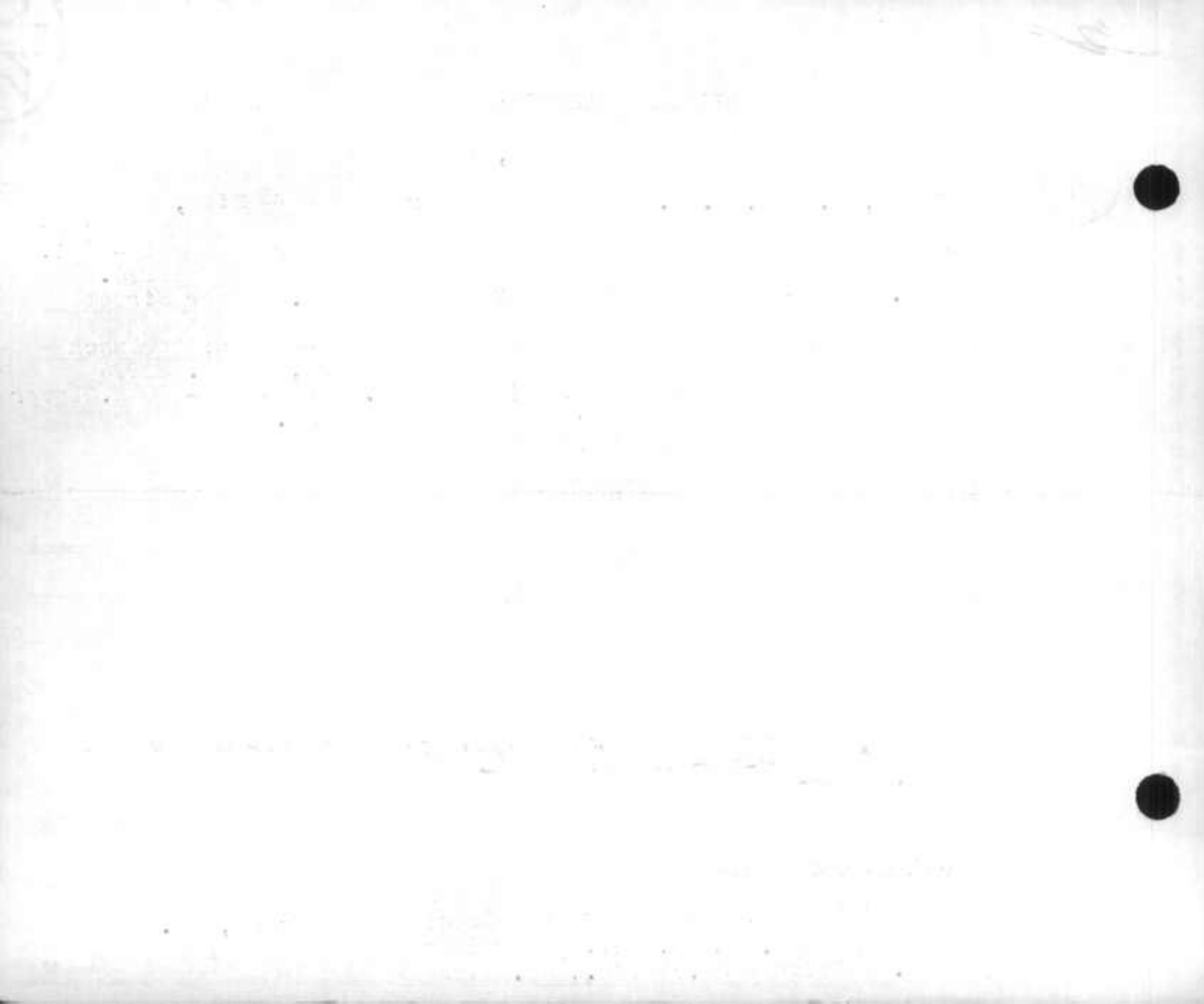
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>February 23, 1984</b> , to <b>MARCH 13, 1984</b> , that (we) lost saw the deceased alive on <b>MARCH 13, 1984</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.			
22b. SIGNATURE <b>Wolock for Gyako</b>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/13/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WOLOCK MD</b>		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/16/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery Baltimore, Md.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>John A. Moran, Inc. Funeral Home</b> ADDRESS <b>3000 E. Baltimore St., Balto., Md. 21224</b>		25. DATE REC'D. BY REGISTRAR <b>MAR 15 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Lidia Davidson-Randall</b>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

D 6 7 9 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lyda G. Henss</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/24/84</b>		2b. HOUR <b>7<sup>02</sup> A M</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-10-1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY - MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTO.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CITY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>
13a. STATE <b>MD.</b>			13b. COUNTY <b>—</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY RENSHAW</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLY AKEHURST</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-09-5415</b>		17. INFORMANT ADDRESS <b>Mr. Herman F. Henss, Jr. - 5301 Valiquet Ave. 21206</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**  
4275  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Anoxic encephalopathy**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **Probable arrhythmia and arrest**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

20 min

7 days

7 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> 19 <b>84</b> , to <b>3/24</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>T. Parran Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/24/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PARRAN</b>		22e. ADDRESS <b>BCH dept of medicine</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3-28-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>
24. FUNERAL DIRECTOR <b>Harley Miller - 7527 Harford Rd.</b>		25a. DATE REC'D. BY REGISTRAR'S SIGNATURE <b>MAR 27 1984</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



490

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediate coronary inquest must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06995

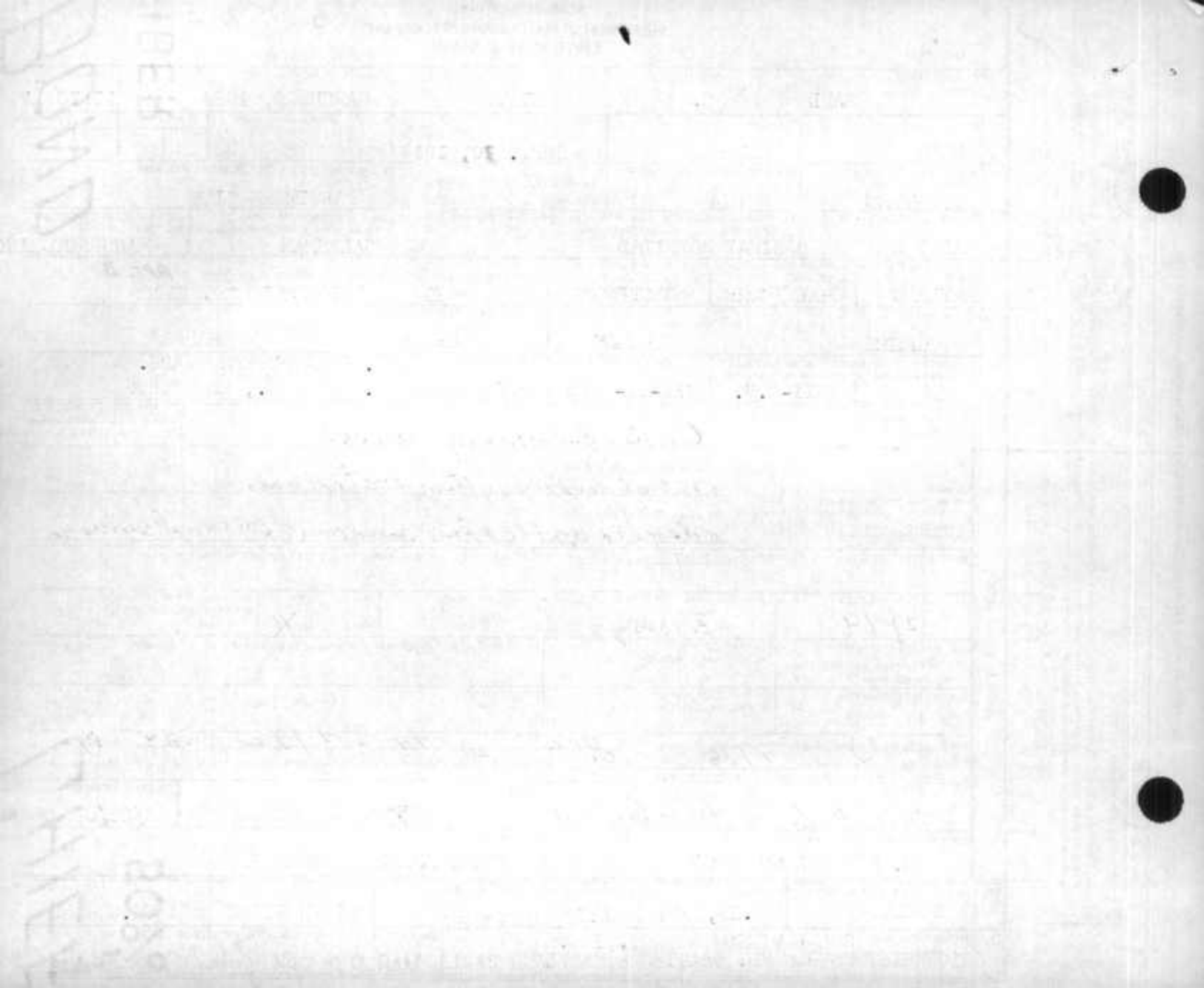
1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAUL C. HERMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 22, 1984</b>			2b. HOUR <b>12:20 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 30, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>IF UNDER 24 HRS. HOURS MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MANUFACTURING</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6658 SANZO RD. 21209</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MAURICE HERMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE HARRIS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. (IF YES, GIVE WAR OR DATES) <b>WWII-A.F.</b>		16c. SOCIAL SECURITY NO. <b>218-01-0800</b>		17. INFORMANT <b>MRS. NORMA HERMAN APT. B</b> <b>6658 SANZO RD. BALTO., MD 21209</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>1609</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Central nervous system metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>adenoid cystic adenocarcinoma of parotid salivary gland</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <b>12/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biopsy</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1979</b> , to <b>3/22</b> , 19 <b>84</b> , that (II) (we) lost <b>saw the deceased alive on 3/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael J. Holliday MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/22/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MICHAEL HOLLIDAY</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 25, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06996

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Catherine D. Herndon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 1, 1984</b>			2b. HOUR <b>5:50A</b> M			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 17 25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE DAVIS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA EPPS</b>			13e. STREET ADDRESS / ZIP CODE <b>3313 DORCHESTER RD. 21215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215 22 2336</b>		17. INFORMANT ADDRESS <b>JAMES DAVIS 5544 NOME AVE.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the Cervix, with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1809</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 26, 19 84</b> , to <b>March 1, 19 84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 1, 19 84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gary W. Merritts</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/1/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary W. Merritts, M.D.</b>					22e. ADDRESS <b>c/o Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>		
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT 4600 LIBERTY HGTS AVE.</b>					25a. DATE REC'D BY REGISTRAR (2b. REGISTRAR'S SIGNATURE) <b>MAR 5 1984</b> <b>Lelia Davidson-Randall</b>				

1974-1975

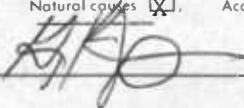

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DATE: 11/11/1911

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 991	
1. DECEASED NAME (TYPE OR PRINT) <b>Edward Hester, Jr.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>3/20/84</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>10</b> YEAR <b>23</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>3/20/84</b>		2d. HOUR <b>11:30</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>auto- 2500 Blk. of W. Pratt St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21223 2521 W. Pratt Street</b>			
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Hester, Sr.</b> LAST <b>Mannie</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Hester</b> MIDDLE <b>Hester</b> LAST <b>Hester</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>226-22-4302</b>		17. INFORMANT <b>May Hester</b> ADDRESS <b>2521 West Pratt Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4254</b> IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Dis. Coronary Obstrc. Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Dis. Coronary Obstrc. Pulmonary Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>3/21/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/27/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest VA</b>				23d. LOCATION CITY OR TOWN <b>Owings Mills,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a. DATE FILED BY REGISTRAR <b>APR 22 1984</b>		25b. REGISTRAR'S SIGNATURE 			

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RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

RECEIVED

FEB 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				6 7 9 8			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Andrew J. Hicks</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 24, 1984</b>		2b. HOUR <b>2:46 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 2 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriett Hicks</b>		13e. STREET ADDRESS / ZIP CODE <b>539 Gold Street 21217</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>217-20-2962</b>		17. INFORMANT ADDRESS Box 250 <b>Nancy Hicks Charlotte Hall, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>0389</b> IMMEDIATE CAUSE (a) <b>Probable Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 Hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (I) (this hospital) attended the deceased from <b>March 24, 1984</b> to <b>March 24, 1984</b> , that (I) (we) lost saw the deceased alive on <b>March 24, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.							
22b. SIGNATURE <b>Charles C. Ridley M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Ridley, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/31/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Bailey Funeral Home</b>		ADDRESS <b>1348 N. Calhoun St. 21217</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1984</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 6999				
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA AMELIA - HICKSON					2a. DATE OF DEATH MONTH DAY YEAR 03 24 84				
2b. HOUR 12:00 A									
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12/8/95		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CITY HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSEW		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13e. STREET ADDRESS / ZIP CODE 629 NEW JERSEY 21221			
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL REGAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HUSTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 215-30-0888		17. INFORMANT ADDRESS MARY PORTER A BOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) HEART DISEASES									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/20, 19 84, to 3/24, 19 84, that (I) (we) lost saw the deceased alive on 3/23, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Andrew Yang					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW YANG					22e. ADDRESS BALTIMORE CITY HOSPITAL, BAL MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/27/84		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD		
24. FUNERAL DIRECTOR NAME J.G. CONNELLY					ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE Julia Friedman-Pandall

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR: Item #6 as per phone w/800 7000 1- STATE REGISTRAR 3/9/84 jp									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie Wilhemina Higdon						2a. DATE OF DEATH MONTH DAY YEAR March 6, 1984		2b. HOUR 8:05 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 95		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland						13b. COUNTY Balto. City		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Riese						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212.05.4648		17. INFORMATION (Daughter-in-law) 226 Poplar Ave. Mrs. Dorothy Higdon GlenBurnie 21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 5-7 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>84</u> , to <u>3-6</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Girgis				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raafat Y. Girgis				22e. ADDRESS St. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 9, 1984		23c. NAME OF CEMETERY OR CREMATORY GlenHaven Mem. Prk.		23d. LOCATION CITY OR TOWN COUNTY STATE GlenBurnie A.A. Maryland			
24. FUNERAL DIRECTOR NAME Dean P. Charlton				ADDRESS Singleton Funeral Home GlenBurnie, Md		25a. DATE REC'D. BY REGISTRAR MAR 8 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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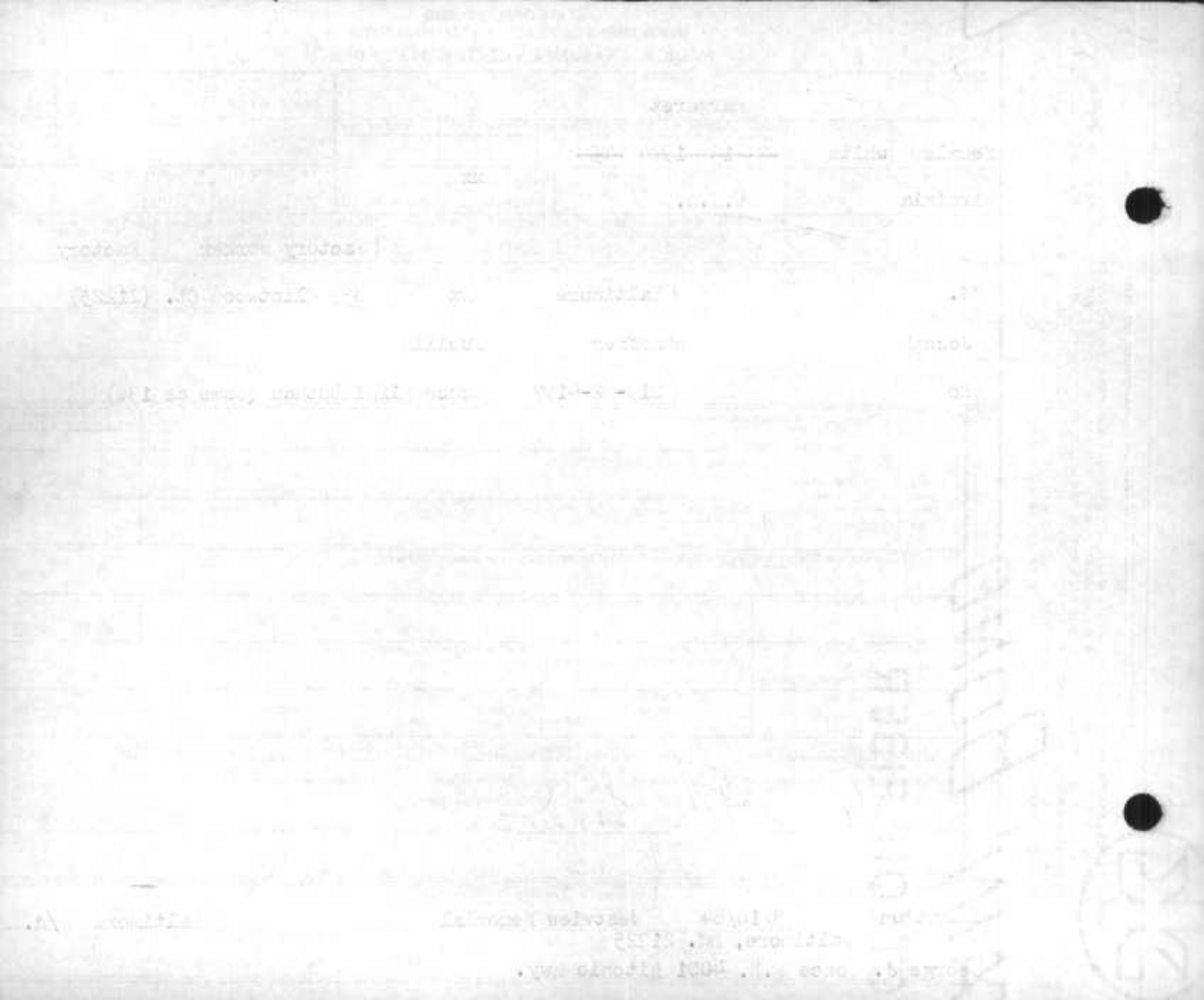
10-10-10

Items 5&6 film #G590 4/5/81 in  
 FOR  
 1- STATE  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR					
Fana Margaret Higginbotham				XX MONTH DAY YEAR 3-13 19 84				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.			
female		white		3-13 1939		45 YRS.		MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR			
Virginia		U.S.A.		XX		WIDOWED		Baltimore City,		1:07 p. M.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				South Baltimore General Hospital				Factory worker				Factory	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.						Baltimore		YES NO		839 Clintwood Ct. (21225)			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Joseph Schaeffer				Lucille									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
No				219-62-4197				Bruce Higginbotham (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Seizure Disorder													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
										YES NO XX			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED					
				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2					
21d. INJURY OCCURRED WHILE AT WORK				21e. PLACE OF INJURY				21f. LOCATION					
NOT WHILE AT WORK				STREET, FACTORY, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from Natural causes, Accident, Suicide, Homicide, Undetermined manner.													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Dennis F. Smyth, M.D.				Assistant				3-14-84					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Dennis F. Smyth, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Cremation				3/16/84		Westview Memorial				CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Baltimore, Md. 21225				MAR 16 1984				Julia Davidson-Randall					
George J. Gonce F.H. 4001 Ritchie Hwy.													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (this certificate should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portion. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked on this certificate as any injury, or other traumatic event, the medical examiner must be notified through the coroner.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 0 0 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>DORIS V. HILDEBRAND</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/15/84</b>				2b. HOUR <b>12<sup>10</sup> P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-26-1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <b>Md.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Grauling</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Manners</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-09-7497</b>		17. INFORMANT <b>Mr. Everett F. Hildebrand</b>				ADDRESS <b>3616 Ravenwood Ave. - 21213</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBROVASCULAR ACCIDENT (PONTINE)</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>HYPER TENSION, ARTHRITIS, DIABETES</b>											
19a. DATE OF OPERATION <b>N/A</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A</b> 19 <b>84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/15/84</b> to <b>3/15/84</b> , that (I) (we) lost saw the deceased alive on <b>3/15/84</b> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jean K. Janda</b>						DEGREE <b>M.D., M.P.H.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/15/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEAN K. JANDA</b>						22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>				23b. DATE <b>3-19-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b>						ADDRESS <b>6415 Belair Rd.-21206</b>		25a. DATE REC'D. BY REGISTRAR <b>MAK 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Robert</b>	

BP



John C. Miller Inc-415 Belair Rd.-21206

Burial 3-19-84 Towson (con)

Balto. Md.

John E. Janda

John E. Janda

3/12

n/a

n/a

n/a

n/a

n/a

n/a

HYPERTENSION

ARTHRITIS, DIABETES

X

CEREBROVASCULAR ACCIDENT (HISTORIC)

CARDIAC ARREST

no

born, Carlisle

born, Emma

Id.

Balto.

x

3018 Ravenwood Ave.-21213

Machine Operator

retired

Balto. Md.

U.S.A.

White

12-26-1918

xx

62

3/12/84

12-26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7003	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR
Maggie			R.	Hill		March 5, 1984
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)
Female		Black		9 16 19		64 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia		USA				Baltimore City
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore		510 Edgewood St.				12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS / ZIP CODE
Thomas			Morgan, Sr			510 Edgewood Street 21229
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO			228-16-7096		Fannie Hill 510 Edgewood Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> <u>4029</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HASCD &amp; medasthnel</u> (c) <u>tumor</u> DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/1983</u> to <u>3/3/1984</u> , that (I) (we) lost saw the deceased alive on <u>3/3/1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE				DEGREE		22c. DATE SIGNED
<u>Nayan Vaywala M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>3/6/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
NAYAN VAYWALA				301 St Agnes med CTR Balt MD 21229		
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		3/9/84		King Memorial Park		Randallstown, Md.
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Wm. C. March F/H 1101 E. North Ave,				MAR 7 1984 <u>John Davidson-Randall</u>		

BP

DO NOT WRITE IN THESE SPACES

THE B

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07004

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) WILLIE NANCY		3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 24 16	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Balt		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Lightner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Gladden		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-65-0252	
17. INFORMANT ADDRESS Robert Hill, Sr. 2707 Delk Court		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>polymicrobial sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/4</u> 19 <u>84</u> to <u>3/5</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/4</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>William H. Hankin</u>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/5/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. HANKIN		22e. ADDRESS Balto. City Hosp. 4940 Eastern Av Baltio 21224		23a. BURIAL, CREMATION, REMOVAL (15) BURIAL		23b. DATE 3/9/84	
23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue		25a. DATE REGD. BY REGISTRAR 06 1984 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randell</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PLUMB

PIERS

3

MADE IN U.S.A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 7 0 0 5  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR B. HINE Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03/18/84</b>			2b. HOUR <b>7:00 P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07/7/98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Great Britain</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. I.R.S. Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>7801 Tilmont Avenue 21234</b>			
13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Parkville</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary J. DeGruchy</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Bromfield Hine</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WW 1</b>						
16b. SOCIAL SECURITY NO. <b>220-38-5576</b>			17. INFORMANT ADDRESS <b>Mr. Arthur Bromfield Hine Jr. Same</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peptic perforation Aorta MI</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CA Lung Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>P. S. Patil</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATEL M.D.</b>			22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Mar. 22, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

BP

1. The first part of the paper is devoted to a discussion of the  
 various methods which have been proposed for the determination of  
 the rate of reaction between a solid and a liquid. It is shown that  
 the most reliable method is that of measuring the change in weight  
 of the solid as the reaction proceeds. This method is applicable to  
 all cases in which the solid is insoluble in the liquid.

2. The second part of the paper is devoted to a discussion of the  
 various factors which influence the rate of reaction between a solid  
 and a liquid. It is shown that the rate of reaction is influenced  
 by the nature of the solid, the nature of the liquid, the temperature  
 of the reaction, and the surface area of the solid.

3. The third part of the paper is devoted to a discussion of the  
 various theories which have been proposed to explain the rate of  
 reaction between a solid and a liquid. It is shown that the most  
 satisfactory theory is that of the collision theory, which states that  
 the rate of reaction is proportional to the number of collisions  
 between the solid and the liquid molecules.

4. The fourth part of the paper is devoted to a discussion of the  
 various applications of the study of the rate of reaction between a  
 solid and a liquid. It is shown that this study has many important  
 applications in the fields of chemistry, physics, and engineering.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07006

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CORDELLA V. HINTON			2a. DATE OF DEATH MONTH DAY YEAR MARCH 3 28 84		2b. HOUR 12:09 A <sub>M</sub>
3. SEX Female	4. RACE NEGRO	5. DATE OF BIRTH MONTH DAY YEAR 9 29 39	6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6620 Vincent Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Post Office
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5612 Belleville Ave. 21207
14. FATHER'S NAME FIRST MIDDLE LAST Robert Washington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Holland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-36-4467	17. INFORMANT ADDRESS Mr. Phillip Hinton - Same as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Cardio-respiratory failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Seizure disorder					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3, 1980, to 3/10, 1984, that (I) (we) last saw the deceased alive on 3/10, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Boonyong P. Thada		DEGREE M.D.		22c. DATE SIGNED 3/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BOONYONG P. THADA		22e. ADDRESS 5356 Reisterstown Rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04/03/84	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, BALTO., Md.
24. FUNERAL DIRECTOR NAME MARSHALL W. JONES, JR. 4101 EDMONDSON AVE., BALTO., Md. 21229			25a. DATE READ BY REGISTRAR MAR 29 1984		

25b. REGISTRAR'S SIGNATURE

FOR COPIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 0 0 7			
FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
LANCASTER HINTON				MARCH 21, 1984 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		11 16 13		70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S. Carolina		U.S.A.				BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		3829 PARK HEIGHTS AVENUE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE		21215	
Joe Hinton		Louise Hills		3829 Park Heights Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		218-01-5240		Willie Mae Hinton		3829 Park Heights Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardiorespiratory arrest							Immed
1629 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of the lung							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1981, 19, to 3, 1983, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel I. Benesh, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/3/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel I. Benesh, MD				22e. ADDRESS 11 Slade Ave Balt, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/28/84		Druid Ridge Cem.		Baltimore Co, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR MAR 27 1984		25b. REGISTRAR'S SIGNATURE Davidson Handell	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 0 0 8	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie Marlyn Hoenig						2a. DATE OF DEATH MONTH DAY YEAR 3/19/84			2b. HOUR 12 33 AM		
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Social Security			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.						13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Ellis Perry						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Helen Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-24-0934		17. INFORMANT ADDRESS J. Richard Hoenig, 3705 Parkside Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PUL MONARY ARREST 5860 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIA IN FRACTION DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) ALCOHOLIC LIVER DISEASE, COROULOPATHY, STAPH INFECTIONS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 14, 1984, to March 19, 1984, that (I) (we) last saw the deceased alive on March 18, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Hoenig						DEGREE		22c. DATE SIGNED 3/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Hoenig						22e. ADDRESS Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/22/84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, 3331 Brehms La,						25a. DATE REC'D. BY REGISTRAR MAR 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

THE UNION MEMORIAL HOSPITAL  
BALTIMORE, MARYLAND

RECEIVED

BALTIMORE CITY

THE UNION MEMORIAL HOSPITAL

BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR Item 21d&21f&22a 1- STATE REGISTRAR 4-6-84 cn					7 0 0 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FREDERICK A. HOERNER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3-21-84</b>			2b. HOUR <b>3:20</b> M		
3. SEX <b>MALE</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-26-1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Custodian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Hoerner</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Deares</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Army WWII</b>		17. INFORMANT ADDRESS <b>Mary G. Hoerner, 4349 Sheldon Ave. Balto., MD 21206</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction.</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 (P.M.) 3-21-1984</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>PT fell down &amp; hit his head</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Church</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Baltimore Balto. Md</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>3-21-1984</b> to <b>3-21-1984</b> , that (I) (we) lost saw the deceased alive on <b>3-21-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Anil Raiker</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3-21-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANIL RAIKER</b>				22e. ADDRESS <b>GOODSAMARITAN HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>3/24/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. MD</b>				
24. FUNERAL DIRECTOR <b>John C. Miller, Inc. 6415 Belair Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>				



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07010

1. DECEASED NAME (TYPE OR PRINT) ADA L. HOFFMAN			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1984		2b. HOUR 8:28P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	8b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN 21204	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Skaggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Joy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 412-34-6941		17. INFORMANT ADDRESS Myrtle V. Harbaugh 1652 Mussula Rd. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6+ yrs 10+ yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-12</u> , 19 <u>83</u> , to <u>3-13</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>8-13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Frederick J. Vollmer, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-14-84	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick J. Vollmer, M.D.		22e. ADDRESS 6100 York Road 435-7636			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 16, '84	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Maryland		
24. FUNERAL DIRECTOR NAME William E. Johnson		ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR MAR 14 1984	
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified by the funeral director.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HUGH VERNON HOFFMASTER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 8, 1984</b>			2b. HOUR <b>11:42 M</b>		p	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 27, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3602 Greenmount Ave. 21218</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franklin Hoffmaster</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Wiles</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Marguerite H. Hoffmaster</b>		ADDRESS <b>Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>FATAL Arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>CORONARY ARTERY DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 mins</b> <b>50 mins</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Hypertension</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <b>11-2</b> , 19 <b>82</b> , to <b>3-8</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>4-21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>Joseph W. Zebley, III</b>					DEGREE <b>MD</b>					22c. DATE SIGNED <b>III-9-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Joseph W. Zebley, III, MD</b>					22e. ADDRESS <b>3809 Greenmount Ave., Balto., MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/12/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Co., MD</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>				
4905 York Road Balto., MD					21212						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  | REG. NO.  |  |
|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELENA HOLLAND</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 84</b>             |  | 2b. HOUR<br><b>10:23</b><br>P M                                     |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Balck</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 8 21</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b><br>YRS.              |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 8b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   | 13c. COUNTY<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>4048 Park Heights Ave.</b>              |  | 13f. CITY OR TOWN<br><b>21215</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sydney Miles</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Tongue</b>   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>ADDRESS<br><b>21215</b><br><b>Jean Brown 4048 Park Heights Ave.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden death Syndrome - Probable</b><br><b>4019</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Cardiac Arrhythmia</b><br>(b) <b>Atrial Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Essential Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes</b> |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b><br><b>X 1 yr</b><br><b>&gt; 12 yrs</b>                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-29</b> , 19 <b>83</b> , to <b>death</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2-2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If I/we) did (did not) view the body after death.   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Alvin R. Sills, MD</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/16/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alvin R. Sills, MD</b>  |  | 22e. ADDRESS<br><b>4432 Park Heights Ave. 21215</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>3/20/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Dailey Funeral Home</b>  |  | ADDRESS<br><b>1348 N. Calhoun St</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified (circle 18 or 21).

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 07013<br>REG. NO.   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Jessie Mae HOLLIDAY</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 6, 1984</b>  |  |   |  | 2b. HOUR<br><b>9:05A<sub>M</sub></b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 11 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MARYLAND Baltimore</b>  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS ZIP CODE<br><b>611 White Rock St. 21217</b>                                 |  |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br><b>Jesse Handy</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br><b>Josephine SALLS</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-20-8230</b>  |  | 17. INFORMANT ADDRESS<br><b>Flossie Rivers 2100 Westwood Ave.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Widely Metastatic Malignant Tumor consistent</b><br><b>1790</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>with origin from Uterus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that <del>XXX</del> (this hospital) attended the deceased from <b>March 2</b> , 19 <b>84</b> , to <b>March 6</b> , 19 <b>84</b> , that <del>X</del> (we) lost saw the deceased alive on <b>March 6</b> , 19 <b>84</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>X</del> (we) (did) <del>(did not)</del> view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Charles Ridley M.D.</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>3/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Ridley, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/10/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion</b>   |  | 23d. LOCATION<br><b>Baltimore</b> COUNTY <b>Md.</b> STATE                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bailey Funeral Home 1348 N. Calhoun St.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |   |  |

100-0

March 6, 1964

HOLLAND

Jessie

Salisbury City

Marland General Hospital

Salisbury

Marland General Hospital

Charles Ridgely, M.D.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JERRY HOLLINGER</b>                     |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 2, 1984</b> |   |  | 2b. HOUR<br><b>06:42pm</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/18/1938</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Joppa</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>36 Court Drive 21085</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sidney Hollinger</b>                 |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Hollinger</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-36-5805</b>  |  | 17. INFORMANT ADDRESS<br><b>Doris C. Hollinger 36 Court Drive</b>                               |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>2791</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acquired ImmunoDeficiency Syndrome</b><br><b>1 year.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>9 days</b> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>84</b> , to <b>3/2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Victor Chang</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/3/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Victor Chang</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL, BALTO, MD</b>                             |  |  |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SP) <b>BURIAL</b> |  | 23b. DATE<br><b>3/7/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery Anne Arundel Co., Md.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
|---|--|----------------------------|--|--|--|--|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc, 1101 E North Avenue</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 05 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |
|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes on lined paper, including the words "March 1945" and "April 1945".

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07015

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES M. HOLLOWAY</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 12, 1984</b>   |  | 2b. HOUR<br>M   |  |
| 1. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 22, 1901</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b>   |  | MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2402 Hamilton Ave.</b>               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lead Burner-</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2402 Hamilton Ave. 21214</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Holloway</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Schmidt</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-7633</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Bertha Holloway Same as # 13e</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ATHEROSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>DIABETES MELITUS</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1982</b> to <b>3-12</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3-10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Donato A. Vargas</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-13-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donato A. Vargas, M.D.</b>   |  | 22e. ADDRESS<br><b>4607 Harford Rd.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIAL)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-15-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Md.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1984</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><i>John Ruck</i>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified to conduct an autopsy.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified to conduct an autopsy.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

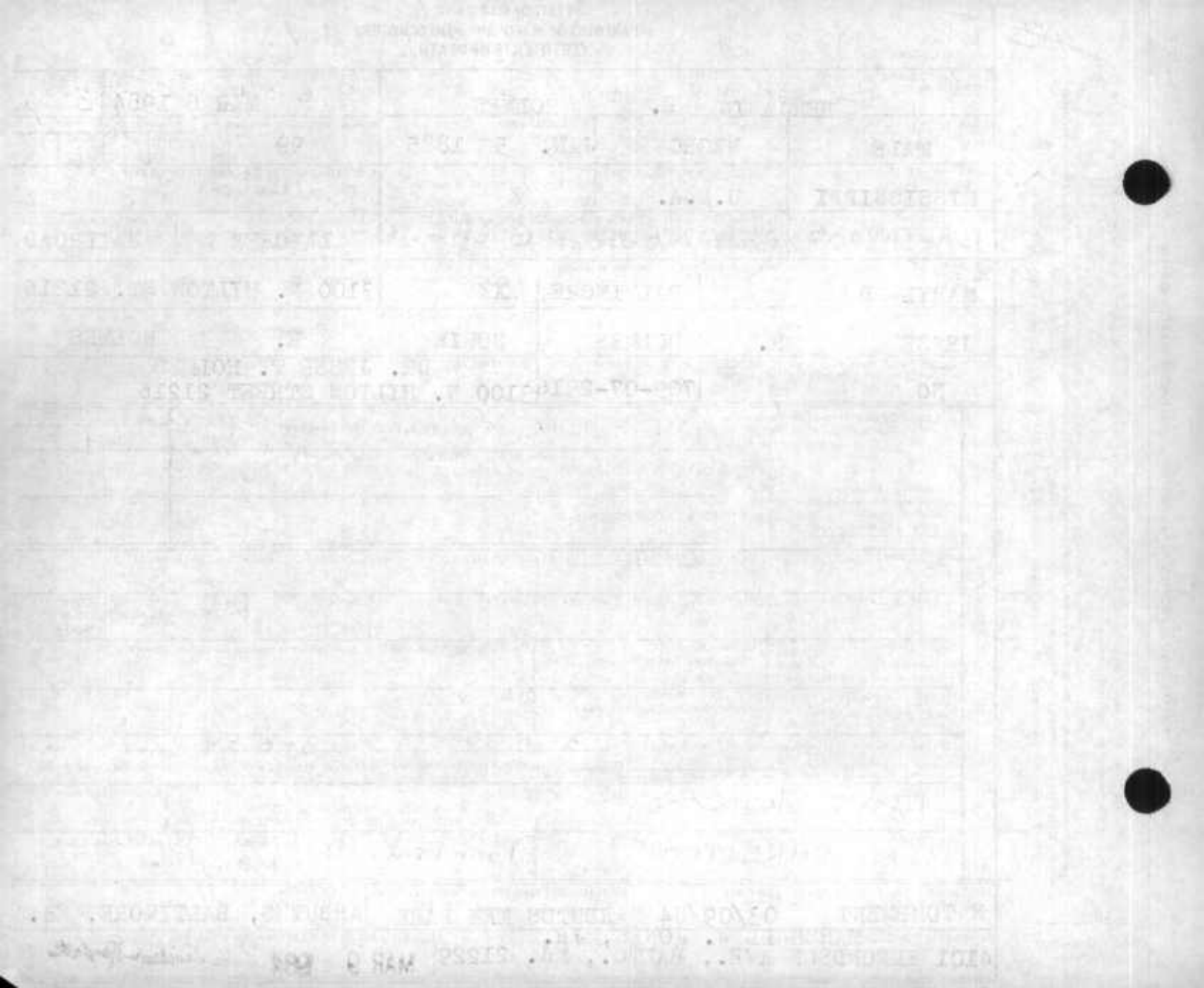
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 07016  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 3.6.84 MAR 6 1984  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BENJAMIN E. HOLMES  |  |  |  | 2b. HOUR 305 PM   |  |   |  |
| 3. SEX MALE  |  | 4. RACE NEGRO  |  | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 5 1885   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSP. Baltimore |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER   |  | 12b. KIND OF BUSINESS OR INDUSTRY RAILROAD  |  |
| 13a. STATE MARYLAND  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN BALTIMORE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST JESSE E. HOLMES  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE SUSIE E. HOLMES   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO. 709-07-2916   |  | 17. INFORMANT DR. JESSE T. HOLMES ADDRESS 3100 N. HILTON STREET 21216   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4151 Bil. Multiple Pulmonary Emboli from<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) }<br>(c) }<br>DUE TO, OR AS A CONSEQUENCE OF<br>Stacc. verus. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-4-84, 19, to 3-6-84, 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE B.N. Shrestha   |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                              |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.N. SHRESTHA  |  |  |  | 22e. ADDRESS PROVIDENT HOSPITAL Baltimore Maryland  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) ENTOMBMENT   |  | 23b. DATE 03/09/84   |  | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PARK   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS, BALTIMORE, Md.   |  |
| 24. FUNERAL DIRECTOR MARSHALL W. JONES, JR. 4101 EDMONDSON AVE., BALTO., Md. 21229   |  |  |  | 25a. DATE REC'D. BY REGISTRAR MAR 9 1984  |  | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |   |   |
|---|--|--|--|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LENA HOLMES</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 16, 1984</b>                                       |  |  | 2b. HOUR<br><b>4:25pm</b>   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 1 07</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PALL MALL NURSING HOME</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>633 N. Aisquith St. Apt H12 21202</b> |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Pat Reveal</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida</b>                                     |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Unknown</b>   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>Rebecca Moore 727 Mello Court</b>                                   |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1809 IMMEDIATE CAUSE (a) METASTATIC CANCER CERVIX</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>DEGENERATIVE DISEASE</b>   |  |  |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>84</b> , to <b>3/16</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>DETROIT M. LEE</b>   |  |  | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/18</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |   |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>3/21/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem. Pk.</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md</b>         |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wm C March</b>                            |   |   |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 01 8

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE KNOWN<br>OF<br>DEATH  |  | 2b. DATE KNOWN<br>OF<br>DEATH   |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                      |  | 2d. HOUR                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY          |  |
| ROSCOE   |  | Male   |  | Black   |  | July 22, 1947   |  | 36 YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. BALTIMORE CITY OR COUNTY OF DEATH       |  |
| Arkansas   |  | USA  |  |   |  | Baltimore City  |  | MD  |  |
| 11. CITY OR TOWN OF DEATH  |  | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |  | 14. KIND OF BUSINESS<br>OR INDUSTRY                                 |  |   |  |
| Baltimore  |  | Johns Hopkins Hospital   |  | Laborer   |  |   |  |   |  |
| 15a. STATE   |  | 15b. COUNTY  |  | 15c. CITY OR TOWN   |  | 15d. INSIDE CITY LIMITS?  |  | 15e. STREET ADDRESS                         |  |
| Maryland   |  | Harford  |  | Aberdeen  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 341 Walker St., 21001                       |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  | 18. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 19. SOCIAL SECURITY NO.   |  | 20. INFORMANT<br>ADDRESS                    |  |
| Milton   |  | Holmes   |  | Mary  |  | Elizabeth   |  | Dorris                                      |  |
| NO   |  | NO   |  | NO  |  | 585-22-3293   |  | Eddie Saddler, 341 Walker St., Aberdeen, MD |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9660 IMMEDIATE CAUSE (a) Stab wounds of thorax<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.                                 |  | 20. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |
| 21. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.   |  |  |  |   |  |   |  |   |  |
| 21a. DATE OF OPERATION   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 21c. AUTOPSY?   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 4:05 P.M. 3-14- 19 84   |  | Subject was stabbed.                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 400 blk. E. Lanvale St., Balto. City, Md.                           |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. TITLE (SPECIFY)<br>M.D. Assistant   |  | 22c. DATE<br>SIGNED   |  | 3-15-84   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |
| Burial   |  | Mar. 28, 1984  |  | Harford Memorial Cdns.  |  | Aberdeen, Harford, Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Tarring Funeral Home, P.A., Aberdeen, MD, 21001-33   |  |  |  | MAR 28 1984   |  | Julia Davidson-Rendall  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07019

REG. NO.

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>PHILIP HOLZMAN  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 13 84 |  |  | 2b. HOUR<br>9 15 AM   |  |  |  |
| 1. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APR. 13, 1907  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINSTEIN HEBREW GERIATRIC HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BAKER                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOODS   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6317 PARK HEIGHTS AVE. 21215   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN HOLZMAN  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH WIELGOLEFSKA  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-32-1341  |  | 17. INFORMANT<br>MRS. BEATRICE HOLZMAN APT. 112<br>6317 PARK HTS. AVE. BALTO., MD 21215  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RECURRENT ASPIRATION PNEUMONIA<br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>LUNG CA SP LOBECTOMY, PARKINSON'S DISEASE   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 2/10, 19 84, to 3/13, 19 84, that (we) last saw the deceased alive on 3/13, 19 84, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>ESTRELLITA O. KELLEY, M.D.  |  |   |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>3/13/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS<br>LEVINSTEIN HEBREW GERIATRIC HOSPITAL   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>MAR. 14, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BNAI JACOB   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or cremation. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

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ALBANY:

WATKINS

PRINTERS

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07020

REG. NO.

|  |  |  |   |  |                                    |  |               |  |  |
|--|--|--|---|--|------------------------------------|--|---------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR   |               |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 3. SEX  |  |                                    | 4. RACE  |               |  |  |
| James E Hood   |  |  | m   |  |                                    | B, K   |               |  |  |
| 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  |                                    | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                       |               |  |  |
| 12 28 18   |  |  | 85 YRS.   |  |                                    | Balti city   |               |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                    | 10. CITY OR TOWN OF DEATH  |               |  |  |
|  |  |  | Balti city MD.  |  |                                    | Balti.   |               |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |               |  |  |
| Lutheran Hosp  |  |  |   |  |                                    |  |               |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |                                    | 13c. CITY OR TOWN  |               |  |  |
| Md   |  |  |   |  |                                    | Balti.   |               |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |               |  |  |
| William E. Hood  |  |  | Ella Mae Hood   |  |                                    | No   |               |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |                                    | ADDRESS  |               |  |  |
| 213-01-5767  |  |  | Ella Mae Hood   |  |                                    | 1611 Ruxton Ave  |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                                    |  |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |                                    |  |               |  |  |
| IMMEDIATE CAUSE (a) anoxic Encephalopathy  |  |  |   |  |                                    |  |               |  |  |
| 4860   |  |  |   |  |                                    |  |               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |  |               |  |  |
| (b) Renal failure  |  |  |   |  |                                    |  |               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |  |               |  |  |
| (c) Pneumonitis  |  |  |   |  |                                    |  |               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |   |  |                                    |  |               |  |  |
| (Ventricular Fibrillation Cardiac arrest)  |  |  |   |  |                                    |  |               |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED              |  |                                    | 20a. AUTOPSY?  |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |               |  |  |
|  |  |  | 3 HOUR A.M. MONTH DAY YEAR                                    |  |                                    |  |               |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY  |  |                                    | 21f. LOCATION  |               |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | [AT HOME STREET, FACTORY, OFFICE, FARM, ETC.]                 |  |                                    | CITY OR TOWN COUNTY STATE  |               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1/84, 1984, to 3/7, 1984, that (I) (we) last saw the deceased alive on 3/6, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) (did not) view the body after death. |  |  |   |  |                                    |  |               |  |  |
| 22b. SIGNATURE   |  |  |   |  |                                    | DEGREE   |               | 22c. DATE SIGNED   |  |
| Mages Bebevanan  |  |  |   |  |                                    | MD   |               | 3/7/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |                                    | 22e. ADDRESS   |               |  |  |
| Mages Bebevanan  |  |  |   |  |                                    |  |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION |  |  |
| Burial   |  |  | 3/12/84   |  | Md. Nat. Mem. Pk.                  |  | Laurel, Md.   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |               | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Wm C March F/H 1101 E. North Ave.  |  |  |   |  |                                    | MAR 13 1984  |               | John Davidson-Randall  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07021  
REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1- FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH  |   | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST MIDDLE LAST  |   | MONTH DAY YEAR  |  |
| William B. Hopkins   |   | March 14, 1984   |   | 1:22p M   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR   |  |
| Male   | Black   | MONTH DAY YEAR   | 62 YRS.   | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |
| S. Carolina  | U.S.A.  |  | BALTIMORE CITY MD.  |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE  | VA MEDICAL CENTER BALTO MD                              |  |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  |
| 13a. STATE   |   | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  |
| Maryland   |   | Baltimore  |   | Baltimore   |  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME   |   | 16. SOCIAL SECURITY NO.   |  |
| FIRST MIDDLE LAST  |   | FIRST MIDDLE LAST  |   | ADDRESS   |  |
| Dennis Hopkins   |   | Isabelle Harper  |   | 239 26 6893   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |
| YES  |   | 239 26 6893  |   | Sarah Watkins 2709 Ashland Avenue   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5185 IMMEDIATE CAUSE (a) <u>ventricular fibrillation; cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>adult respiratory distress syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?   |  |
|  |   |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|  |   | HOUR A.M. MONTH DAY YEAR   |   |   |  |
| 21d. INJURY OCCURRED   |   | 21e. PLACE OF INJURY   |   | 21f. LOCATION   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>March 12-</u> 19 <u>84</u> , to <u>March 14</u> 19 <u>84</u> , that (X) (we) lost saw the deceased alive on <u>March 14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death.   |   |  |   |   |  |
| 22b. SIGNATURE   |   | DEGREE   |   | 22c. DATE SIGNED  |  |
| John A. Vitarello Jr. M.D.   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   | 3/14/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS   |   |   |  |
| JOHN A. VITARELLO JR MD  |   | 3900 Loch Raven Blvd. Baltimore, Md 21218  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| BURIAL   |   | 3/19/84  |   | Garrison Forest VA Mills. Md.   |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE RECEIVED BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |
| NAME   |   | ADDRESS  |   |   |  |
| Wm C March F/H Inc. 1101 E. North Avenue   |   | MAR 16 1984  |   | John Davidson-Randall   |  |

BP \_\_\_\_\_



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 0 7 0 2 2<br>REG. NO.   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Frances Stella Hoppa</i>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>March 17, 1984</i>   |  |   |  | 2b. HOUR<br><i>7:00 A.M.</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>8 20 03</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS.                               |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>814 South Highland Avenue</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Housework</i>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13. STREET ADDRESS<br><i>814 South Highland Ave. 21224</i>                      |  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Francis Karcz</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Stella Rzepka</i>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>213-50-5950</i>  |  | 17. INFORMANT ADDRESS<br><i>Catherine Hoppa 814 S. Highland Ave. 21224</i>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>2500 (1) Hypertension of Cardiac - Vascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>2500 (2) Acute Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>1655 C.V.D.</i>                   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> 19 <i>78</i> to <i>3/17</i> 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on <i>3/5</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Joseph B. Liberto, M.D.</i>   |  |   |  | DEGREE<br><i>M.D.</i>   |  |   |  | 22c. DATE SIGNED<br><i>3/19/84</i>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Joseph B. Liberto, M.D.</i>  |  |   |  | 22c. ADDRESS<br><i>3508 BANK ST - Baltimore, Md 21224</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-20-84</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Stanislaus</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City Md.</i>         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i>  |  |   |  | ADDRESS<br><i>901 S. Conkling St</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 20 1984</i>                             |  |  |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                      |  |  |  |

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2420 v. 903, 904  
2421 v. 905, 906  
2422 v. 907, 908  
2423 v. 909, 910  
2424 v. 911, 912  
2425 v. 913, 914  
2426 v. 915, 916  
2427 v. 917, 918  
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2430 v. 923, 924  
2431 v. 925, 926  
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2444 v. 951, 952  
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2456 v. 975, 976  
2457 v. 977, 978  
2458 v. 979, 980  
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2467 v. 997, 998  
2468 v. 999, 1000  
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2528 v. 1119, 1120  
2529 v. 1121, 1122  
2530 v. 1123, 1124  
2531 v. 1125, 1126  
2532 v. 1127, 1128  
2533 v. 1129, 1130  
2534 v. 1131, 1132  
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2667 v. 1397, 1398  
2668 v. 1399, 1400  
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2670 v. 1403, 1404  
2671 v. 1405, 1406  
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2680 v. 1423, 1424  
2681 v. 1425, 1426  
2682 v. 1427, 1428  
2683 v. 142

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07023

|   |  |  |   |  |  |   |  |  |   |   |  |
|---|--|--|---|--|--|---|--|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |   |  |
|   |  |  | LORETTA C. HOWARD   |  |  | March 7, 1984   |  |  | 11 A.M.   |   |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE  |   |  |
| FEMALE  |  |  | WHITE   |  |  | DEC. 25 1899  |  |  | 84 YRS.   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |
| MD.   |  |  | U.S.A.  |  |  |   |  |  | BALTIMORE CITY MD.  |   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |   |  |
| BALTIMORE   |  |  | 3246 PELHAM AVENUE  |  |  | HOMEMAKER   |  |  | -   |   |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |   |  |
| MD.   |  |  | -   |  |  | BALTIMORE   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |   |   |  |
| unknown   |  |  | unknown   |  |  | 3246 PELHAM AVE. 21213  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS   |   |  |
| NO  |  |  | 215-01-0764   |  |  | THOMAS HOWARD   |  |  | 9113 SIMMS AVE. 21234   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>   |  |  |   |  |  |   |  |  |   | IMMEDIATE                                       |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CORONARY ARTERY DISEASE</u>   |  |  |   |  |  |   |  |  |   | SEVERAL YEARS                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HYPERTENSION</u>   |  |  |   |  |  |   |  |  |   | 10-20 YEARS                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |   |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |  |
|   |  |  | P.M. 19   |  |  |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN COUNTY STATE   |   |  |
|   |  |  |   |  |  |   |  |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>23 DEC</u> 19 <u>72</u> , to <u>PRESBY</u> 19 <u>83</u> , that (I) (we) last<br>saw the deceased alive on <u>21 NOV</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE  |  |  | DEGREE  |  |  | 22c. DATE SIGNED  |  |  |   |   |  |
| <u>1 S. Hill</u>  |  |  | M.D.  |  |  | 8 March 1984  |  |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |   |  |  |   |   |  |
| DR. DIXON HILLS   |  |  | 3501 ST. PAUL ST., SUITE 143  |  |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |  |
| Cremation   |  |  | 3/8/84  |  |  | Greenmount  |  |  | Baltimore Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |
| Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |  |  |   |  |  | MAR 12 1984   |  |  | <u>[Signature]</u>  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 07024<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Luther Howard  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 31 84  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 25 31   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3401 FAIRVIEW AVENUE |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 13e. STREET ADDRESS / ZIP CODE<br>3401 Fairview Ave. 21216  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Howard   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Georgian Howard  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>241-42-6655   |  | 17. INFORMANT<br>ADDRESS<br>Magdene Howard 3401 Fairview Avenue   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a).<br>4029 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) Myocardial infarction<br>gave rise to immediate } Myocardial infarction<br>cause (a), stating the } (c)<br>underlying cause last. |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/29/80 19, to 3/31/84 19, that (I) (we) last saw the deceased alive on 4/29/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>J. Shropkey MD  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>4/2/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Shropkey   |  | 22e. ADDRESS<br>4734 PARK HARB 21215  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>4/7/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk. Arbutus,   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>APR 2 1984  |  |   |  |

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DIVISION OF VITAL RECORDS, 201 WESTON ST., BALTIMORE, MARYLAND 21201  
 HUGHINS, WILLIAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the body be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 07025   |   |
|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM HUDGINS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 17, 1984</b> |   | 2b. HOUR<br>4:55 P M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 21 19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Doc Hudgins</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Mary Jones</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>716 Washington Place 21201</b>                             |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Delores E. Davis 1640 Thomas Ave.</b>                               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>1509</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Severe Pneumonia</b><br>(c) <b>Esophageal Carcinoma</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>3 weeks</b><br><b>6 months</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/17/84</b> to <b>3/17/84</b> , that (I) (we) lost <b>3/17/84</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Paul Katzenstein</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/17/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL KATZENSTEIN</b>   |  | 22e. ADDRESS<br><b>601 N. BROADWAY</b>  |  | 22f. CITY OR TOWN<br><b>Baltimore</b> MD  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/21/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  | 1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>   |   |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 3B shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |  |   | 7026  |   |
|---|---|--|---|---|---|
| 1 - FOR STATE REGISTRAR   |   |  |   | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>SISTER MARY W. HUNDLEY O.S.B.</b>   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3-20-84</b>   |   | 2b. HOUR <b>3 AM</b>  |
| 3. SEX <b>♀ (female)</b>  | 4. RACE <b>B</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 03</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>                                      |   |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore City</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hosp. 22 S. Greenest, Balt MD</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>nun</b>                            |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>   |
| 13a. STATE <b>MD</b>  | 13b. COUNTY <b>Balt</b>   | 13c. CITY OR TOWN <b>Balt.</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        | 13e. STREET ADDRESS / ZIP CODE <b>701 Gun Road Balt. MD 21227</b>                 |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Webster</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Robinson</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |   | 16b. SOCIAL SECURITY NO. <b>217-58-167</b>   |   | 17. INFORMANT ADDRESS <b>Sister Virginia Fish 701 Gun Road</b>                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>week</b> |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |  |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that I (this hospital) attended the deceased from <b>3/13</b> 19 <b>84</b> to <b>3/20</b> 19 <b>84</b> , that I (we) last saw the deceased alive on <b>3/20</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do not) see the body after death.                          |   |  |   |   |   |
| 22b. SIGNATURE <b>Robert W. Nudelman</b>  |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>3/20/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert W. Nudelman MD</b>  |   | 22e. ADDRESS <b>22 S. Greenest Balt. MD 21209</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (S) <b>BURIAL</b>   | 23b. DATE <b>3/24/84</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem,</b>   | 23d. LOCATION CITY OR TOWN <b>Baltimore,</b>  | COUNTY <b>MD.</b>   | DATE  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc, 1101 E North Avenue</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Davidson-Randell</b> |   |   |

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Robert W. Jones  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 7021  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILTON WILLARD HUNT, SR.</b>   |  |   |  | 2a. DATE OF DEATH <b>March 2 '84</b>   |  |  |  | 2b. HOUR <b>12 30 PM</b>   |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 8, 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>67</b>  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN.  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                     |  |  |  |   |  |
| 13. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |  |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired - Board of Education</b> |  | 16. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE <b>Maryland</b>   |  |   |  | 17b. COUNTY <b>Baltimore</b>   |  | 17c. CITY OR TOWN <b>Lutherville</b>   |  | 17d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 17e. STREET ADDRESS / ZIP CODE<br><b>629 W. Seminary Ave. 21093</b>   |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oliver Hunt</b>  |  |   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice R. Teal</b>  |  |  |  |  |  |   |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  | 21. SOCIAL SECURITY NO.<br><b>215-28-9111A</b>   |  | 22. INFORMANT ADDRESS<br><b>Milton W. Hunt, Jr. 1 Airway Circle 21204</b>                              |  |  |  |   |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest 2° anemia</b><br><b>2000</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diffuse histiocytic lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>diagnosed Aug 1982</b> |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |  |  |  |  |   |  |
| 24. DATE OF OPERATION   |  |   |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 26. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 31. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 34. I certify that (I) (this hospital) attended the deceased from <b>Feb 24</b> 19 <b>84</b> , to <b>march 2</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>march 2</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |   |  |
| 35. SIGNATURE<br><b>Yvette Oquendo</b>  |  |   |  | 36. DEGREE<br><b>MD</b>  |  |  |  | 37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 38. DATE SIGNED<br><b>march 2/84</b>  |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>YVETTE OQUENDO, M.D.</b>   |  |   |  | 40. ADDRESS<br><b>THE UNION MEMORIAL HOSPITAL</b>  |  |  |  |  |  |   |  |
| 41. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   |  | 42. DATE<br><b>3-5-84</b>  |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Methodist</b>   |  | 44. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hampstead, Balto, Maryland</b>   |  |   |  |
| 45. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |   |  | 46. ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>  |  | 47. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>  |  | 48. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 would be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARY LOU HUNTER                            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 11, 1984   |  | 2b. HOUR<br>10:00AM                       |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 19 1908  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>75 YRS.               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress                  |  | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. STATE<br>Maryland   |  |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c. STREET ADDRESS<br>942 Punjab Circle 21221             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ellett Buck  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie A. Graham                               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |   | 16b. SOCIAL SECURITY NO.<br>220-03-2990   |  |   |
| 17. INFORMANT<br>2F Ginger View Ct. 21030  |  |   | Paul E. Hunter, Sr. = Cockeysville, MD.   |  |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE, STATUS POST TRACHEOSTOMY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CEREBROVASCULAR ACCIDENT</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

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|--|---|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>MEDICAL CERTIFICATION  |   |   |  |
| 19a. DATE OF OPERATION<br>FEBRUARY 23, 1984  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RESPIRATORY INSUFFICIENCY | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 24</u> , 19 <u>84</u> , to <u>MARCH 11</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. |   |   |  |
| 22b. SIGNATURE<br><i>Mukesh Luhar</i> MD   |   | 22c. DATE SIGNED<br>MARCH 11, 1984  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MUKESH LUHAR, MD.   |   | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231 |  |

|   |                        |  |  |
|---|------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                              | 23b. DATE<br>3/14/1984 | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>White Marsh Maryland |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222 |                        | 25a. DATE REC'D. BY REGISTRAR<br>MAR 14 1984     |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07029

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EIMER L HURD   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03-26-84                        |  |  | 2b. HOUR<br>8:45  |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/25/09  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                          |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD          |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHN A. DEBARTON |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                              |   |
| 13a. STATE<br>md  |  |   | 13b. COUNTY<br>Baltimore   |  | 13c. STREET ADDRESS / ZIP CODE<br>4010 Bateman Ave 21216                             |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown               |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-78-2807 |  | 17. INFORMANT<br>Chart.  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic adenocarcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST. |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)   |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 23</u> , 19 <u>84</u> , to <u>Mar 26</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Mar 26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                    |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br><u>Elizabeth G. Mosley</u>  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>3/26/84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elizabeth G. Mosley  |  | 22e. ADDRESS<br>Deaton Med Center Charles St Baltimore.   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial  |  | 23b. DATE<br>3-28-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Springfield Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lynchville Carroll Md |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry W. Haight   |  | ADDRESS<br>Lynchville, Md.  |  | 25a. DATE RECD. BY REGISTRAR<br>MAR 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07030

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN O. HURST</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 9, 1984</b>            |   |  | 2b. HOUR<br><b>7:45 AM</b>   |   |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 17, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 10a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>10. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY OR TOWN<br><b>Millersville</b>  |  | 10d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 10e. STREET ADDRESS / ZIP CODE<br><b>513 Point Field Dr. 21108</b>   |  |
| 11. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George F. Obrecht</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Schmidt</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 03 1231</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>H. Webster Hurst, Jr. 631 Lakeland Road Severna Park, Md.</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Sclerosis</b><br><b>3310</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alzheimer's Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Brain Syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b><br><b>unknown</b><br><b>unknown</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Aug 11, 1961</b> to <b>3/9/84</b> 19____, that (he/she) last saw the deceased alive on <b>2/20/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Martin E. Singewald</b>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN E. SINGEWALD</b>  |  |   | 22e. ADDRESS<br><b>116 Chase St Baltimore Md 21202</b>                 |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  |   | 23b. DATE<br><b>3/12/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Mausoleum</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MITCHELL-WIEDEFELD HOME, INC.</b>   |  |   |  |   | ADDRESS<br><b>6500 York Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>                 |  |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                    |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the data after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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**Author's address:**

*L. L. Long*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at 1-800-368-2263.

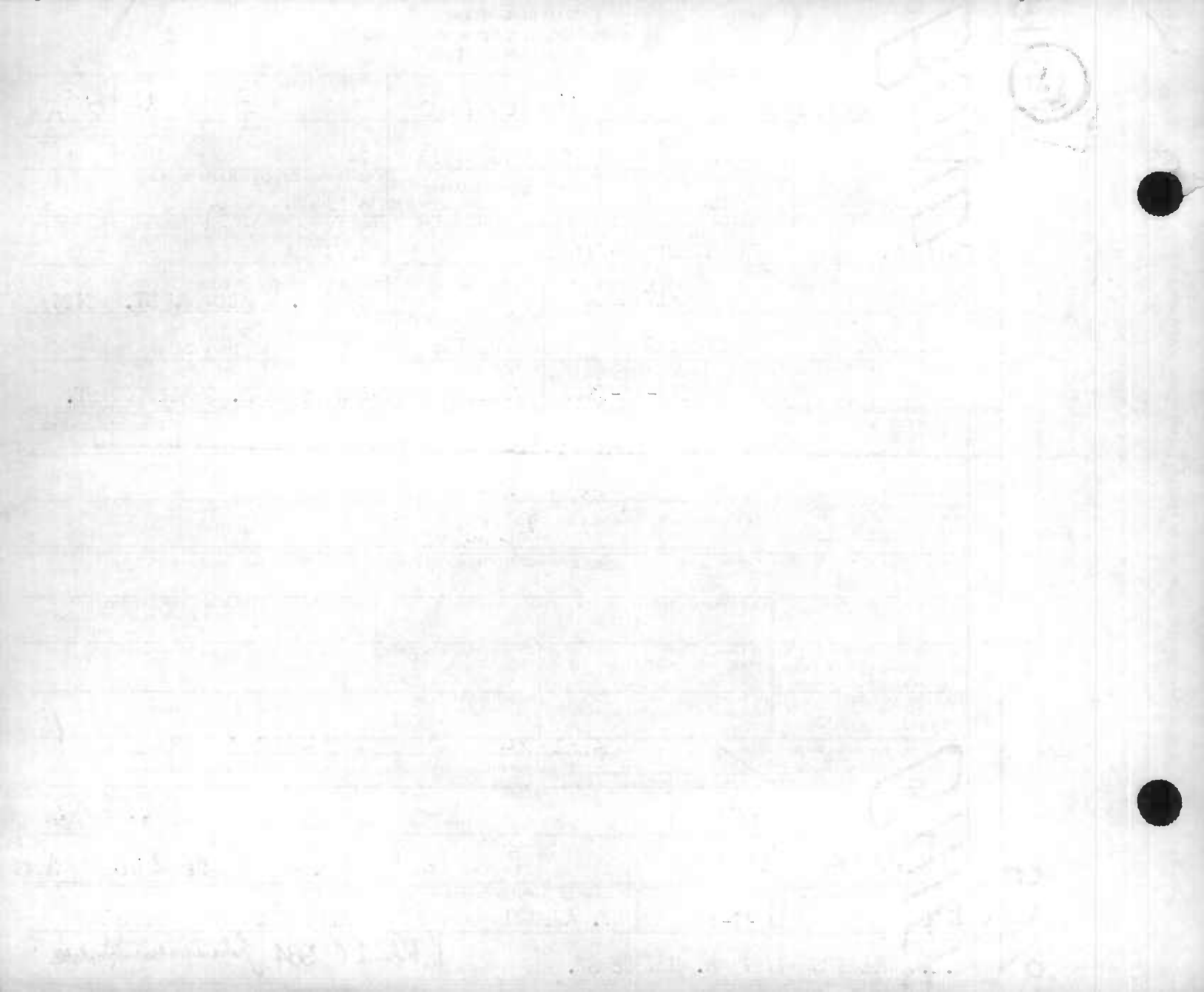
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>TAUBE HURWITZ</b>   |  |  |  | 2a. DATE OF DEATH<br><b>3/9/84</b>  |  |  |  |
| 1. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 18, 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ATTORNEY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT LAW</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY POSTER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHEL UNKNOWN</b>   |  | 13e. STREET ADDRESS<br><b>5736 CROSS COUNTRY BLVD.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-24-0897</b>   |  | 17. INFORMATION<br><b>MR. LOUIS F. FRIEDMAN, ATTY.</b>  |  |  |  |
|  |  |  |  | <b>1400 1st NAT'L. BANK BLDG. #21202</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarct - ventricular fibrillation</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic hypertension and chronic CHF.</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic pulmonary disease.</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 1980</b> to <b>time of death</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/12/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles S. Angell MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/10/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles S. ANGELL, MD</b>  |  | 22e. ADDRESS<br><b>611 Park Ave. 21201</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>3-11-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI TFILOH CONG.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Rendell</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |  |  |  |   | 07032  |                          |                                   |  |
|--|--|--|---|--|---|--|--|--|---|--|--------------------------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |   |  |  |  |   | REG. NO.   |                          |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CARLOS</b>   |  |  |   |  | MIDDLE <b>Hutchins</b>  |  |  |  |   | LAST   |                          |                                   |  |
| 2a. DATE OF DEATH  |  |  |   |  | MONTH <b>3</b>  |  | DAY <b>13</b>  |  | YEAR <b>84</b>  |  | 2b. HOUR <b>045</b> A.M. |                                   |  |
| 3. SEX <b>MALE</b>   |  |  | 4. RACE <b>BLACK</b>  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.                           |   | IF UNDER 1 YEAR  |                          | IF UNDER 24 HRS.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.           |   |  |                          |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>  |  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>                            |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b> |                          | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>2002 N. SMALLWOOD ST. 21216</b>   |  |                          |                                   |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |                          |                                   |  |
| FIRST <b>WILLIAM</b> MIDDLE <b>HUTCHINS</b> LAST   |  |  |   |  | FIRST <b>VERTIE</b> MIDDLE <b>BRANSON</b> LAST  |  |  |  |   |  |                          |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  |   |  | 16b. SOCIAL SECURITY NO. <b>212-16-8867</b>   |  | 17. INFORMANT ADDRESS <b>WILLIAM HUTCHINS 2002 N. SMALLWOOD ST.</b>                          |  |   |  |                          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br><b>2089</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Sepsis - renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Leukemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |   |  |  |  |   |  |                          |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |  |   |  |   |  |  |  |   |  |                          |                                   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                          |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |                          |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |  |                          |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/12/84</b> , 19 <b>84</b> , to <b>3/13/84</b> , 19 <b>84</b> , that (I) (we) lost above, the deceased alive on <b>3/13/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |  |  |  |   |  |                          |                                   |  |
| 22b. SIGNATURE <b>BUI</b>  |  |  |   |  | DEGREE  |  |  |  |   | 22c. DATE SIGNED <b>3/13/84</b>  |                          |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CAN Q. BUI</b>  |  |  |   |  | 22e. ADDRESS <b>Provident Hospital 2600 liberty Hgts Ave.</b>   |  |  |  |   |  |                          |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE <b>3-17-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>  |  |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE |   |  |                          |                                   |  |
| 24. FUNERAL DIRECTOR NAME <b>E.L. PHILLIPS</b> ADDRESS <b>1721 N. MONROE ST.</b>   |  |  |   |  | 25a. DATE REG'D. BY REGISTRAR <b>MAR 14 1984</b> REGISTRAR'S SIGNATURE <b>John Davidson</b>   |  |  |  |   |  |                          |                                   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 7 0 3 3  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BESSIE HYMON   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 22, 1984                     |   |   | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>4 15 10   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1330 DIVISION STREET |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |   |  |   |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>1330 Division Street 21217  |  |   |  |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Hall   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Lipston        |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown   |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Robert B. Mack 1330 Division Street    |  |   | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOT BY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Daniel M. M.D.  |  |   | DEGREE<br>M.D.   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3/23/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel M.  |  |   | 22e. ADDRESS<br>8872 Belair Road Balto Md 21236                        |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   | 23b. DATE<br>3/28/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |  |   | 25a. DATE OF BURIAL<br>MAR 27 1984                      |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

X

(11)

Handwritten text, possibly a title or header.

Handwritten text at the bottom of the page, including a date and possibly a signature.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 7 0 3 4  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                              |   |  |
|---|--|--|---|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Anna Uvine Hynes</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 8, 1984</i> |   | 2b. HOUR<br><i>1:15 a.m.</i> |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Nov. 17, 1931</i>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>52</i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.           |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>2819 Indiana Street, Apt. 21230</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Domestic</i>                        |  |
| 13a. STATE<br><i>Maryland</i>   |  |  |   | 13b. COUNTY<br><i>---</i>   |                              | 13c. CITY OR TOWN<br><i>Baltimore</i>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James Kreczmer</i>                     |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Jennie Sweeting</i>   |                              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>216-28-5216</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Edgar F. Hynes, Jr. Same as #13</i>  |                              |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *metastatic Breast Carcinoma*  
*1749*  
DUE TO, OR AS A CONSEQUENCE OF  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>march</i> , 19 <i>75</i> , to <i>2/20</i> , 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on <i>2/20/84</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Marvin J. Feldman M.D.</i><br><i>Dr. Stuart H. Brager, M.D.</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Marvin J. Feldman M.D.</i><br><i>Dr. Stuart H. Brager, M.D.</i>  |  |  |  | 22e. ADDRESS<br><i>2360 West Joppa Rd., Balto., Md. 21093</i>  |  |   |  |

|   |  |                               |  |   |  |   |  |
|---|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3/12/1984</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City, Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCully Funeral Homes</i><br><i>Balto., Md., 21225</i><br><i>237 E. Patapsco Ave.,</i> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 13 1984</i>               |  |   |  |
|   |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jehia Davidson-Randall</i>       |  |   |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN PENCIL IN ITEM 19. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |   |  |   |  |   |  | 7 0 3 5   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sandy Sue Imler   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>3-31 1984                  |  |   |  |   |  |   |  |  |  | 2b. HOUR<br>M<br>5:51<br>a- M                            |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>20-66   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>17 YRS.                          |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3-31 1984                 |  |   |  |   |  |   |  |  |  | 2d. HOUR<br>M<br>5:51<br>a- M                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital - STU |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secty. |  |   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Job Filling                                    |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Md.  |  |                  |  | 13b. COUNTY<br>Carroll  |  |   |  | 13c. CITY OR TOWN<br>Sykesville   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  | 13e. STREET ADDRESS<br>4801 Old Washington Rd.                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CARL Leroy Imler   |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Connie Elene Ellis     |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  |   |  |   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>?            |  |   |  |   |  |   |  |  |  | 17. INFORMANT ADDRESS<br>CARL L. Imler - Sykesville, Md. |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Traumatic Injuries with complications<br>8120<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  |   |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>5:45 P.M. 3-28 1984   |  |   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver in auto/auto impact |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road |  |   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt. 99 & Marrioville Rd., Howard Co., Md.              |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |  |                  |  |   |  | TITLE (SPECIFY)<br>Deputy Chief                                     |  |   |  |   |  | DATE SIGNED<br>3-31-84  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |                  |  |   |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  |   |  | 23b. DATE<br>4-3-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Imber Valley Cemetery   |  |   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Imber Bedford Md. |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry W. Haight  |  |                  |  |   |  | ADDRESS<br>Sykesville, Md.  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 4 1984   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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Mr. Carl

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the funeral director may be retained by the funeral director for use at the burial/interment. The funeral director should be detached for use at the burial/interment. The funeral director should be detached for use at the burial/interment. The funeral director should be detached for use at the burial/interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07036

| FOR<br>1- STATE<br>REGISTRAR  |  |  |  | WITNESSES   |  |  |  | WITNESSES  |  |   |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DANNY L. INGERSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 22, 1984</b>  |  |  |  | 2b. HOUR<br><b>6:36AM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 5, 1952</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>                                       |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                        |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Service tech.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Micro filmer</b>   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Laurel</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br><b>20707</b><br><b>9165 H-Hitching Post La.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Ingerson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Audrey Keller</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-54-4042</b>  |  | 17. INFORMANT<br><b>Joanne E. Ingerson</b>  |  |  |  | ADDRESS<br><b>same as #13</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4241</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS - post op complication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>S/P Cardiac Surgery for Cong Heart Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b><br><b>1 wk</b><br><b>3 wks</b> |  |  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Liver failure, Renal Failure, + thrombocytopenia + petechiae</b>   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>2-23-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>A-V valve incompetence</b>  |  |   |  | 20a. APOPS<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-28</b> 19 <b>84</b> , to <b>3-22</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3-22</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Wm C Doolley MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>3/22/84</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm C Doolley</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>3/24/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Washington Crematory, Inc.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, P.G.Co. Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>FLECK FUNERAL HOME, INC</b>  |  |  |  | ADDRESS<br><b>7601 Sandy Spring Rd. Laurel, Md. 20707</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1984</b>  |  |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |  |  |   |  |

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Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO. 07037   |   |   |  |  |   |  |
|---|--|--|--|--|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   |  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  |  | March 18 1984  |   |   |  |  | 9:30P M   |  |
| 3 SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN.  |  |
| F   |  | W  |  | March 23 1885  |  | 98 YRS.   |   |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |  |   |  |
| MD  |  | USA  |  |  |  | Baltimore City MD.  |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| Baltimore   |  | 6713 Old Hartford Rd   |  |  |  | At Home   |   |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS                     |  |  |   |  |
| 13a. STATE 13b. CITY 13c. OR TOWN   |  |  |  |  |  |   | 6713 Old Hartford Rd Baltimore MD 21234 |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |   |  |  |   |  |
| Charles H. Myers  |  |  |  |  | Emma C. Pietsch  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS                   |  |  |   |  |
| NO  |  |  |  |  |  |   | Family Records                          |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Emboli, probable  |  |  |  |  |  |   |   |  |  | minutes   |  |
| 4151 } DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Venous Stasis, legs   |  |  |  |  |  |   |   |  |  | years   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |   |  |  |   |  |
| Severe Osteoarthritis Knees   |  |  |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
|   |  |  |  | P.M. 19  |  |   |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
|   |  |  |  |  |  |   |   |  |  |   |  |
| 22a. I certify that (I) (the physician) attended the deceased from 2/14, 1974, to 3/18, 1984, that (I) (we) lost saw the deceased alive on 2/24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |  |   |   | 22c. DATE SIGNED   |  |   |  |
| William Benson M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |  |  |   |   | 3/20/84  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |   | 22e. ADDRESS   |  |   |  |
| William P. Benson MD  |  |  |  |  |  |   |   | 3506 N. Calvert St   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SP. GRV.)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                            |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| Burial  |  |  |  | 3-21-84  |  | Dry Ridge Cem   |   | Baltimore MD   |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |  |   |   |  |  |   |  |
| Evans Chapel of Memories 8800 Hartford Rd   |  |  |  |  |  |   |   |  |  |   |  |
| BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |   |   |  |  |   |  |
| FEB 23 1984 1a. Registrar's Signature   |  |  |  |  |  |   |   |  |  |   |  |

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NOTICE

AMCO VALLEY

11/19/01

11/19/01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |              |                 |  |  |  |  |   |               | REG. NO. 07038  |  |   |  |  |  |
|---|--|--------------|-----------------|--|--|--|--|---|---------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |              | FIRST<br>Robert |  |  | MIDDLE<br>J                                    |  |   | LAST<br>Isley |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 3/2/84 19  |  | 2b. HOUR<br>M                                |  |
| 3. SEX<br>M   |  | 4. RACE<br>W |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/5/83   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 7      |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |               | 2c. DATE PRONOUNCED DEAD<br>3/2/84 19                       |  | 2d. HOUR<br>P M   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  |              |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |              |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE   |               |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>MD  |  |              |                 | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTO                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |               | 13e. STREET ADDRESS<br>21231<br>1724 EASTERN AVE            |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNK   |  |              |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NANCY ISLEY   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |               |   |  | 16b. SOCIAL SECURITY NO.<br>NONE  |  | 17. INFORMANT<br>MOTHER ABOVE                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u><br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |              |                 |  |  |  |  |   |               |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |              |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |               |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |              |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |               |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |              |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accidents <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .  |  |              |                 |  |  |  |  |   |               |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |              |                 | TITLE (SPECIFY)<br>M.D. Dep. Chief   |  |  |  | MEDICAL EXAMINER  |               |   |  | DATE SIGNED<br>3/3/84   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |              |                 | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |  |  |   |               |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |              |                 | 23b. DATE<br>3/6/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN |  |   |               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.    |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. G. CONNELLY  |  |              |                 |  |  | ADDRESS<br>300 MACE                            |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1984   |               | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i> |  |   |  |  |  |

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07039

REG. NO.

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                          |   |  | 2b. HOUR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Paul Luther Isom  |  |   | March 3, 1984   |   |  | M  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 2, 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)<br>2409 Brohawn Ave 21230 |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Maryland  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2409 Brohawn Ave 21230  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Emmett Isom  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bessie Line |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF 1955, GIVE WAR OR DATES)<br>None   |   | 17. INFORMANT<br>Velma Isom   |  | ADDRESS<br>Same As # 13  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Adeno carcinoma of the lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) tobacco smoking<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years |  |   |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Chronic Obstructive Lung Disease  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1, 1984, to March 3, 1984, that (I) (we) lost saw the deceased alive on March 1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>T.E. Hobbins MD   |  |   |   | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/3/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T.E. HOBBS, MD   |  |   |   | 22e. ADDRESS<br>295 GREENE ST BALT. MD 21201  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>March 5, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Monte Vista Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Blue Field Mercer Virginia  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>McCully Funeral Home   |  |   |   | ADDRESS<br>Balt. MD. 21225  |  | 25a. DATE REC'D BY REGISTRAR<br>MAR 5 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Sha Davidson   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07040

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY C. JACKSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-4-84</b>                   |   |  | 2b. HOUR<br>MIN.<br><b>11:50 P</b>   |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>70</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic Work</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>607 PA. AVE 21201</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John D. 1995</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Lee</b>      |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-22-1056</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Elmer D. 1996 1714 N. Franklin St</b>           |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>CVA, COPD, Decubitus ulcer.</b>  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-24-84</b> 19 <b>84</b> , to <b>3-4-84</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3-4-84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sitaukat</b>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-7-84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SITAUKAT Y. KHAN</b>  |  |   | 22e. ADDRESS<br><b>1528 King William Drive, Belts</b>                  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/9/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>W. A. Brown</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall A. Hayes 638 N. Gilman St</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1984</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Rodell</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Health and Mental Hygiene Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LIBRARY



*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |   |  |   |  | REG. NO.                                     |  |
|---|--|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT J. JACKSON</b>   |  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 14, 1984</b>   |  |   | 2b. HOUR<br><b>M</b>                                       |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 27 24</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3800 EGERTON ROAD</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                       |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3800 Egerton Road 21215</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-20-1682</b>  |   | 17. INFORMANT ADDRESS<br><b>Angela Sampson 910 Bunche Road</b>                                      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>Coronary Artery Disease -</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Sudden death)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Sudden -</b> |  |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/4/81</b> 19 to <b>present</b> 19, that (I) (we) lost saw the deceased alive on <b>12/29</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>C. GAKUBA</b>  |  |  |   |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-15-84</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   |   | 22e. ADDRESS<br><b>6000 Reisterstown Rd Pikesville Md 21208</b>                                     |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>3/17/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park Randallstown, Md.</b> |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR (REGISTERAR'S SIGNATURE)<br><b>MAR 16 1984 Julia Davidson Randall</b> |  |   |  |  |  |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

07042

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES PETER JACOBS</b>                |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 13 84</b> |   |  | 2b. HOUR<br><b>4 A-M</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 01 47</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37 Y.</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COMPUTER SPEC.</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TECH. SYSTEMS</b>                |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>P.G.</b>  |   | 13c. CITY OR TOWN<br><b>BOWIE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2621 FELTER LANE BOWIE MD 20715</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES P. JACOBS JR.</b>            |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE BIRCKHEAD</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>214-44-6915</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>KARIN JACOBS 2621 FELTER LANE; BOWIE, MD.</b>  |  |   |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute non-lymphatic leukemia</b><br><b>2089</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02/08/1984</b> to <b>03/13/1984</b> , that (I) (we) lost saw the deceased alive on <b>03/13/1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Chandra Prakash Belani</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>03/13/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHANDRA PRAKASH BELANI</b>  |  |  |  | 22e. ADDRESS<br><b>UMCC UMH Balto md-21201</b>                                       |  |  |  |

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                    |  | 23b. DATE<br><b>03-14-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1984</b>      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The attending physician and the medical examiner must be consulted within 24 hours after death. The death certificate should be detached for use as the burial-transit permit. Then please remove the death certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

CHARLES 92-6 TACOS

3 13 24 A

MALE

10 02 17

BALTIMORE CITY

MD

BALTIMORE CITY DIST. 12 M. H. MONTAGUE

MD

BOWIE

2221 PETERMAN BOWIE RD

CHARGE

Acct. verified by the business

02/11/24

02/10/24

02/11/24

02/11/24

Charles Robert Brown

CHARLES ROBERT BROWN / JUNE 1944 / BALTO MD - 2124

02-11-24

02-11-24

Item 4 per ph.

+16/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07043

REG. NO.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Baby Boy-Turner James  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 30 84 |  |  | 3. HOUR<br>8:40 P M  |  |
| 3. SEX<br>Boy-male  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 30 84  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>1 37  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  | 13b. CITY OR TOWN<br>Balto City  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>1912 E Lafayette Ave. 21013   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cliffton James  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sharron   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrest<br>7651<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) prematurity<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Dae Hoon Lee  |  |  |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/30/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dae Hoon Lee   |  |  |   | 22e. ADDRESS<br>MERCK HOSP.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal   |  | 23b. DATE<br>4/12/84   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board   |  |  |   | ADDRESS<br>Balto., Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1984   |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| Michael (Milan)  |  | JANOWITZ  |  | (YOVANOVICH)  |  | March 3, 1984  |  | 4:00A  |  | M   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN                            |  |
| M  |  | W   |  | July 18 1901  |  | 82 YRS.  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |   |  |
| Serbia   |  | U.S.A.  |  |   |  | Baltimore City MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |
| Baltimore  |  | 118 South Gilmore Street 21223  |  | Foundry Worker  |  | B&O Railroad   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE  |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS   |  |   |  |
| Maryland   |  | ---   |  | Baltimore   |  |  |  | 1514 McHenry Street 21223  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |  |  |   |  |
| Jovan Yovanovich   |  | Mileva (UNKNOWN)  |  |   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |   |  |
| Yes  |  | WW-I  |  | Florida 33563   |  |  |  |  |  |   |  |
|  |  | 705-03-9325   |  | Dorothy Stewart/60 Orchard Ct/Palm Harbor   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal disease</u><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>1519</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1519</u> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 hours |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-13-83</u> , 19 <u>83</u> , to <u>11/3/83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased on <u>11/3/83</u> , 19 <u>83</u> , above, (I) (we) did not view the deceased on the date and hour and from the causes stated   |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | 10 CHICKORY COURT DEGREE<br>GLEN ARM. MD. 21057   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | IRS NO: 520-90-9164   |  |   |  | 22e. ADDRESS   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| Burial   |  | 03/07/84  |  | Loudon Park Cemetery  |  | Baltimore City, Md. 21229  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Walters Funeral Home/Pratt & Stricker Streets  |  | Balto Md 21223  |  |   |  | MAR 6 1984   |  | John Davidson  |  |   |  |





RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Tekla Jarkowski</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3 31 84</b>                      |  |  | 2b. HOUR <b>6<sup>45</sup> PM</b>  |  |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89 90</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unknown</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>  |  |  | 13b. COUNTY <b>unknown</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>            |  |  | 13e. STREET ADDRESS <b>631 S. HENWOOD AVE</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>A 603-447 RR</b>                         |  |  | 17. INFORMANT <b>BENICE WATKINS</b> ADDRESS <b>506 DELAWARE AVE</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest.</b><br><b>5990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>UTE Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>~5 days.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/31 19 84</b> to <b>3/31 19 84</b> that (I) (we) last saw the deceased alive on <b>3/31 19 84</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Ronald Takamoto</b> MD  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>3/31/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Takamoto</b>  |  |  | 22e. ADDRESS <b>Mercy Hosp, 301 St. Paul Place, Baltimore 21202.</b> |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE <b>4/4/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>                                  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>3525 FLEET ST</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 4 1984</b>                      |  |  | 25b. REGISTRAR'S SIGNATURE <b>John Paulson</b>   |  |   |  |

BP

12810  
W.H. 12/12/1911  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   | 07046<br>CERTIFICATE OF DEATH  |                                   | REG. NO.  |  |
|--|--|--|---|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |   | 2a. DATE OF DEATH  |                                   | MONTH DAY YEAR  |  |
| Grace ELAINE JARRETT   |  |  |   | 3.14.84  |                                   | 2b. HOUR 9:06 A.M.  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR   |  |
| FEMALE   | BLACK  | MONTH DAY YEAR   |   | XXX 49 YRS.  |                                   | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |   |  |
| JAMAICA  | U.S.A.   |  |   | BALTIMORE CITY   |                                   | MD.   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| BALTIMORE, MD  | MERCY Hospital   |  | Professor   |  | Nursing                           |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |   | 13c. INSIDE CITY LIMITS?   |                                   | 13d. STREET ADDRESS   |  |
| 13a. STATE   |  | COLUMBIA   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 7912 TAMAR DRIVE APT 301  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | 16. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT   |  |
| FIRST MIDDLE LAST  |  | FIRST LAST   |   | 133.40.3475  |                                   | 7001 12th AVENUE S. MINNEAPOLIS, MTNN. 55417                        |  |
| WILFRED JARRETT  |  | LOUISE PRINCESS GORDON   |   |  |                                   |   |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 18b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |   |  |
| NO   |  | 133.40.3475  |   | LESLIE G. BONNEY   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | 20a. AUTOPSY?   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| IMMEDIATE CAUSE (a) 4254   |  |  |   | DUE TO, OR AS A CONSEQUENCE OF   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |   | (b) CARDIO MYO PATHY   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   | DUE TO, OR AS A CONSEQUENCE OF   |                                   |   |  |
|  |  |  |   | (c) VIRAL MYO CARDITIS   |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |  |   |  |                                   |   |  |
| Pneumonia (chronic)  |  |  |   |  |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   | 22c. DATE SIGNED  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |                                   | 3.14.84   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |                                   |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | STREET CITY OR TOWN COUNTY STATE   |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3.06. 19.84, to 3.14. 19.84, that (I) (we) lost saw the deceased alive on 3.14. 19.84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |   |  |
| 22b. SIGNATURE   |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   |   |  |
| Joseph J. Roche M.D.   |  |  |   |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                                   | 23b. DATE   |  |
| Joseph J. Roche M.D.   |  | 301 ST. PAUL STREET, BALTI, MD.  |   | CREMATION  |                                   | 3/16/1984   |  |
|  |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION   |  |
|  |  |  |   | GREEN MOUNT CREMATORY  |                                   | BALTIMORE, MARYLAND   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |
| WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222   |  | MAR 16 1984  |   | Julia Davidson-Randall   |                                   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 07047  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>RAYMOND  |  | MIDDLE  |  | LAST<br>JENKINS  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR<br>3 2 84                     |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 29, 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>pill coater  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>mfg. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12c. STREET ADDRESS<br>116 Paradise Avenue 21228  |  | 13a. STREET ADDRESS  |  | 13b. CITY OR TOWN<br>Baltimore   |  | 13c. COUNTY<br>Catonsville                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie Jenkins   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01-5635               |  | 17. INFORMANT<br>Mrs. Florence Jenkins   |  | ADDRESS<br>116 Paradise Ave 21228            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MARKED, ORGANIZING BRONCHOPNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>OBSTUNDED MENTAL STATUS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>MARKED GENERALIZED ATHEROSCLEROSIS</u><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>4409</u> <u>DAYS</u><br><u>8 YEARS</u> |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u>   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>James E Taylor</u>  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br>3/2/84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES E TAYLOR  |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>March 5, 1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn A.A. Maryland                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home   |  | ADDRESS<br>1328 Sulphur Spring Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>                                   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portion. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

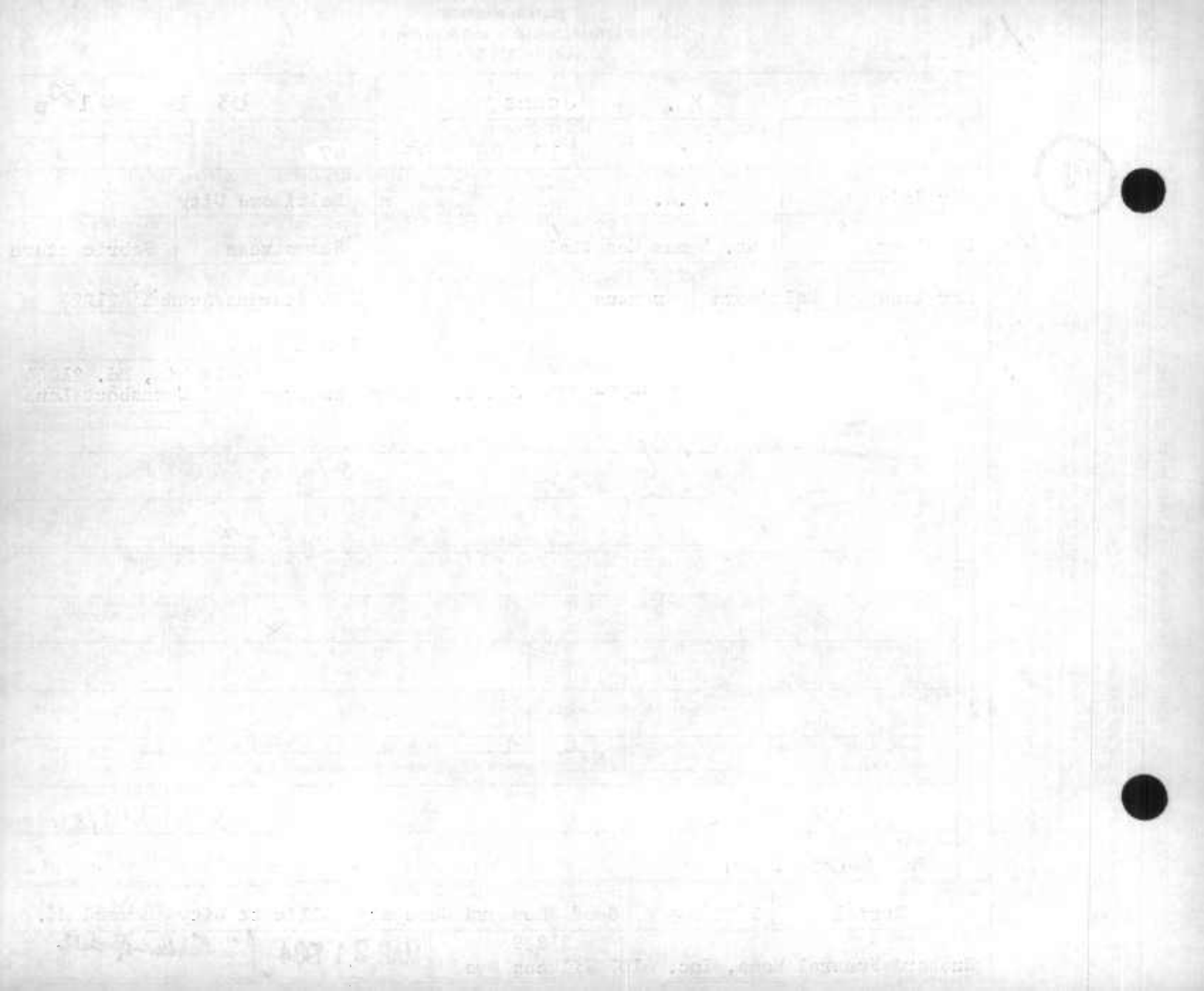
IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, medical examiner should be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 07048   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1 - STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EMMA K. JOHNS  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 19 84 150 p.m.   |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 28 36   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fabric store  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Arbutus   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-32-0993  |  | 17. INFORMANT ADDRESS<br>Joe G. & Emma Landeros 6027 Turnabout Lane Columbia, Md. 21044   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Resp. failure 2nd Cardiorespirat. failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bil. pulm. embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable reprints, Anoxic encephalopathy</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-9</u> , 19 <u>84</u> to <u>3-19</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>W. Kim</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/19/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OK DONF KIM  |  |   |  | 22e. ADDRESS<br>900 caton Av. St. Agnes Hosp. Baltimore   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/22/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Shepherd Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City Howard Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |   |  | 21229<br>ADDRESS  |  | 25a. DATE RECD. BY REGISTRAR<br>MAR 21 1984  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson - Randall</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07049

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |                         |   |  |  |                               |
|--|-------------------------|---|--|--|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MRS. <b>VERGIE M. JOHNS</b> |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-10-84</b> |  | 2b. HOUR<br><b>10:30 P.M.</b> |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>BLACK</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>   |                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>       |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>       |                         | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |                               |
| 10. CITY OR TOWN OF DEATH<br><b>City</b>                           |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                               |
| 13a. STATE<br><b>Maryland</b>                                      |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>4017 Liberty Hgts AVE</b>  |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Swain</b>     |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Oma Smith</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |                               |
| 16b. SOCIAL SECURITY NO.<br><b>212-22-2265</b>                     |                         | 17. INFORMANT<br><b>Lillie G. Smith</b>   |  | ADDRESS<br><b>3321 Avondale Avenue</b>   |                               |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**2500**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>01-02-19-84</b> , to <b>03-10-19-84</b> , that (1) (we) lost<br>saw the deceased alive on <b>3/10/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (if (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Sissag Awoka</b>  |  |  |  | DEGREE<br><b>MD.</b>   |  | 22c. DATE SIGNED<br><b>3/10/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sissag Awoka</b>   |  |  |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>                                       |  |   |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>3/15/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem Pk.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Md.</b> |  |
|---|--|-----------------------------|--|---|--|--|--|

|  |  |                                       |  |   |  |   |  |
|--|--|---------------------------------------|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b> |  | ADDRESS<br><b>1101 E North Avenue</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |
|--|--|---------------------------------------|--|---|--|---|--|



Female + Black  
Virginia  
City  
Lutheran Hospital

11

Baltimore

101 Liberty Street

215-22-2222

208 COTTON FIB



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ALICE T. JOHNSON   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 13, 1984   |  |  |  | 2b. HOUR<br>1:50AM   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 4 10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br>205 S. Herring Ct., 21231                                     |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Stewart   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Imogene Stewart  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>224-05-8221A  |  | 17. INFORMANT<br>ADDRESS<br>Imogene Q. Pettaway 1504 Lanhorn Cour              |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION?</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CONGESTIVE HEART FAILURE</u> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>MARCH 12</u> , 19 <u>84</u> , to <u>MARCH 13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MARCH 13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Nazemi M-D   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>3/13/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NAZEMI, M.D.  |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD. 21231  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |   |  | 23b. DATE<br>3/19/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1984                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Dawson-Randall   |  |  |  |



DAILEY M M

20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07051

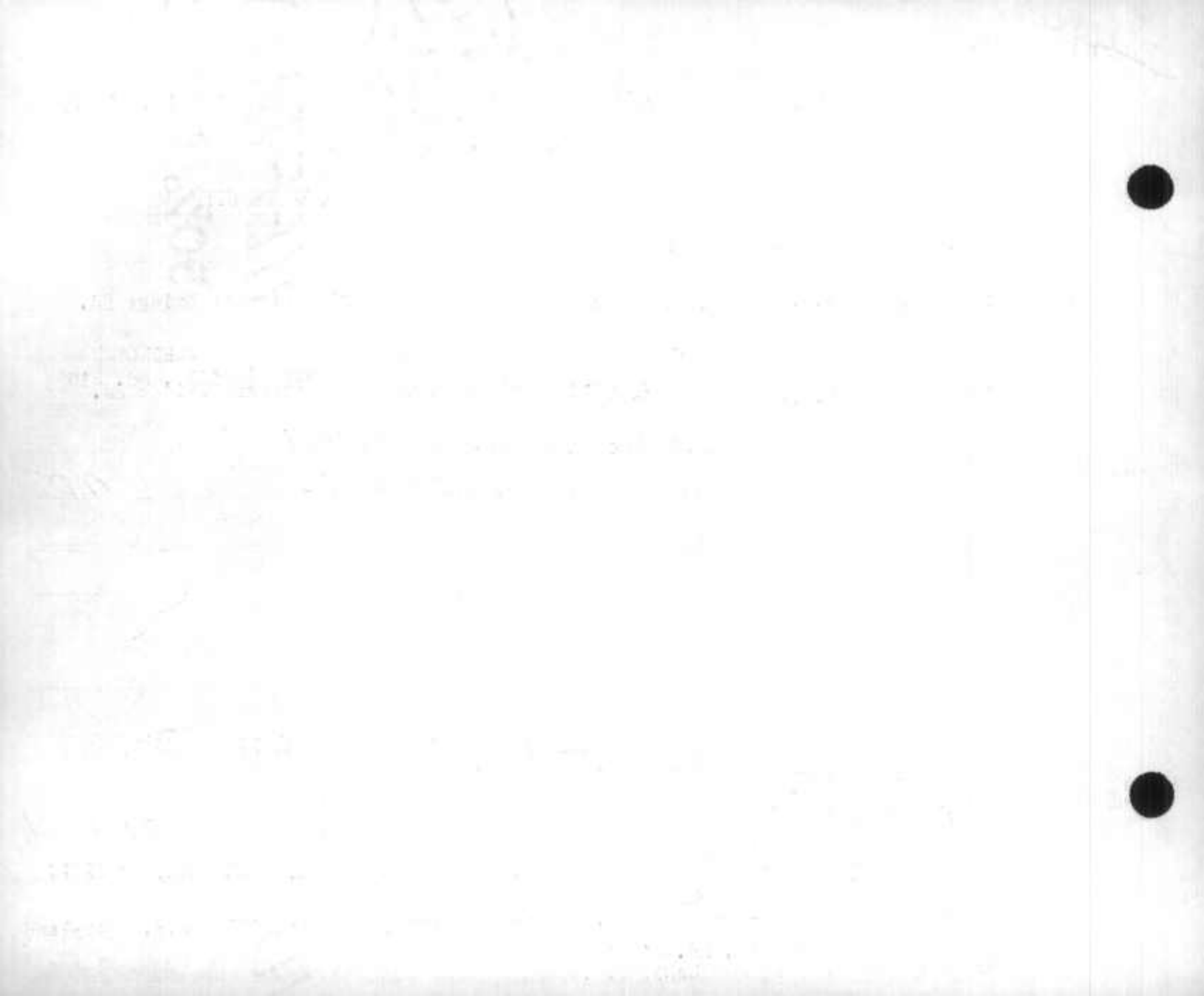
1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Edward Johnson  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 14, 1984                 |   |  | 2b. HOUR<br>12:15p M   |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 13 12  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER BALTO MD |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. CITY OR TOWN<br>A.A.   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>823 Governors Bridge Rd. 21035 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL JOHNSON   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH WASHINGTON |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II  |   | 17. INFORMANT<br>ADDRESS<br>BESSIE DAVIS 823 Davidsonville, Md. 21035   |  | 21035<br>Governors Bridge Rd.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Candida-pulmonary Arrest</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Esophageal Ca</u><br>6 MOS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 7</u> , 19 <u>84</u> , to <u>March 14</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>March 14</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>C Bradley MD</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED<br><u>3/14/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>C Bradley</u>  |  |  |   | 22e. ADDRESS<br><u>3900 Loch Raven Blvd. Baltimore, Md 21218</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br><u>3-20-84</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Md. Veterans Cemetery</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Crownsville A.A. Maryland</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>WILLIAM REESE &amp; SONS MORTUARY, P.A.</u>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 21 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                     |  |   |  |

BP.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before signing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. |  |
|---|--|--|--|---|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Coy Johnson</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 12 84</b>                             |  | 2b. HOUR<br><b>2335</b> M  |  |          |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>26 30</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                              |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |          |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Helper</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Box Factory</b>  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |  |  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Late Andrew Johnson</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Late Addie Davis</b>          |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>408-44-5018</b>  |  | 17. INFORMANT ADDRESS<br><b>21229 Mrs Gladys Johnson 714 Primson St Balto Md</b>  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Massive Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs.</b> |  |  |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Hypertension.</b>  |  |  |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |          |  |
| 22a. I certify that <b>44</b> (this hospital) attended the deceased from <b>3-12</b> 19 <b>84</b> to <b>3-12</b> 19 <b>84</b> , that <b>(we)</b> most saw the deceased alive on <b>3-12</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <b>(we did)</b> (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>D.P. Malayaman MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>3-13-84</b>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.P. Malayaman, MD</b>  |  |  |  | 22e. ADDRESS<br><b>4001 Wilkens Ave Balto 21229</b>   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>March 16'84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Ellicott City Maryland</b>       |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br><b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1984</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson Randall</b>  |  |          |  |

BP



To Messrs

at Messrs

at Messrs

late Andrew Johnson

late Abbie Davis

No

Mrs. Givens Johnson 1111 E. Princeton St. Baltimore

21111

Helper Box Factory

at Messrs

at Messrs

at Messrs

at Messrs

at Messrs

Harry H. Wicks and Columbia and Elliott City  
March 16, 1884 Good Shepherd  
Baptist

Elliott City Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |  |  |  |   |  |  |  | REG. NO. 07053   |  |                    |  |
|---|--|---------------|--|--|--|---|--|--|--|--|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) (HOUSTON) (HUSTON) (HANSTON) (JOHNSON)   |  |               |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED 3/3/84 19                                      |  | 2b. HOUR 10:30 A M |  |
| 3. SEX Male   |  | 4. RACE Black |  | 5. DATE OF BIRTH 8 29 16   |  | 6. AGE (IN YEARS) 67 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD 3/3/84 19   |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                          |  |                    |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                    |  |
| 13a. STATE Md.  |  |               |  | 13b. COUNTY Balto.   |  | 13c. CITY OR TOWN Balto.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 334 Avondale Avenue 21215                                    |  |                    |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Isaac Johnson   |  |               |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Delia Pratt   |  |   |  |  |  |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes.   |  |               |  | 16b. SOCIAL SECURITY NO. WWII  |  | 17. INFORMANT ADDRESS Wayco O. Johnson 3340 Avondale Ave                      |  |  |  |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                         |  |               |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |               |  |  |  |   |  |  |  |  |  |                    |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |                    |  |
| 21g. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |               |  |  |  |   |  |  |  |  |  |                    |  |
| ACTUAL SIGNATURE [Signature]  |  |               |  | TITLE (SPECIFY) M.D. Dep. Chief  |  |   |  | DATE SIGNED 3/4/84   |  |  |  |                    |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.   |  |               |  | ADDRESS 111 Penn St., Balto., Md. 21201  |  |   |  |  |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |               |  | 23b. DATE 3/9/84   |  | 23c. NAME OF CEMETERY OR CHURCH Galilee AME Zion                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE McFarland, N.C.  |  |  |  |                    |  |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave.   |  |               |  |  |  | 25a. DATE REC'D. BY REGISTRAR 7 MAR 7 1984 [Signature]                        |  |  |  |  |  |                    |  |

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THE UNIVERSITY OF CHICAGO LIBRARY



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198 1 MAY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

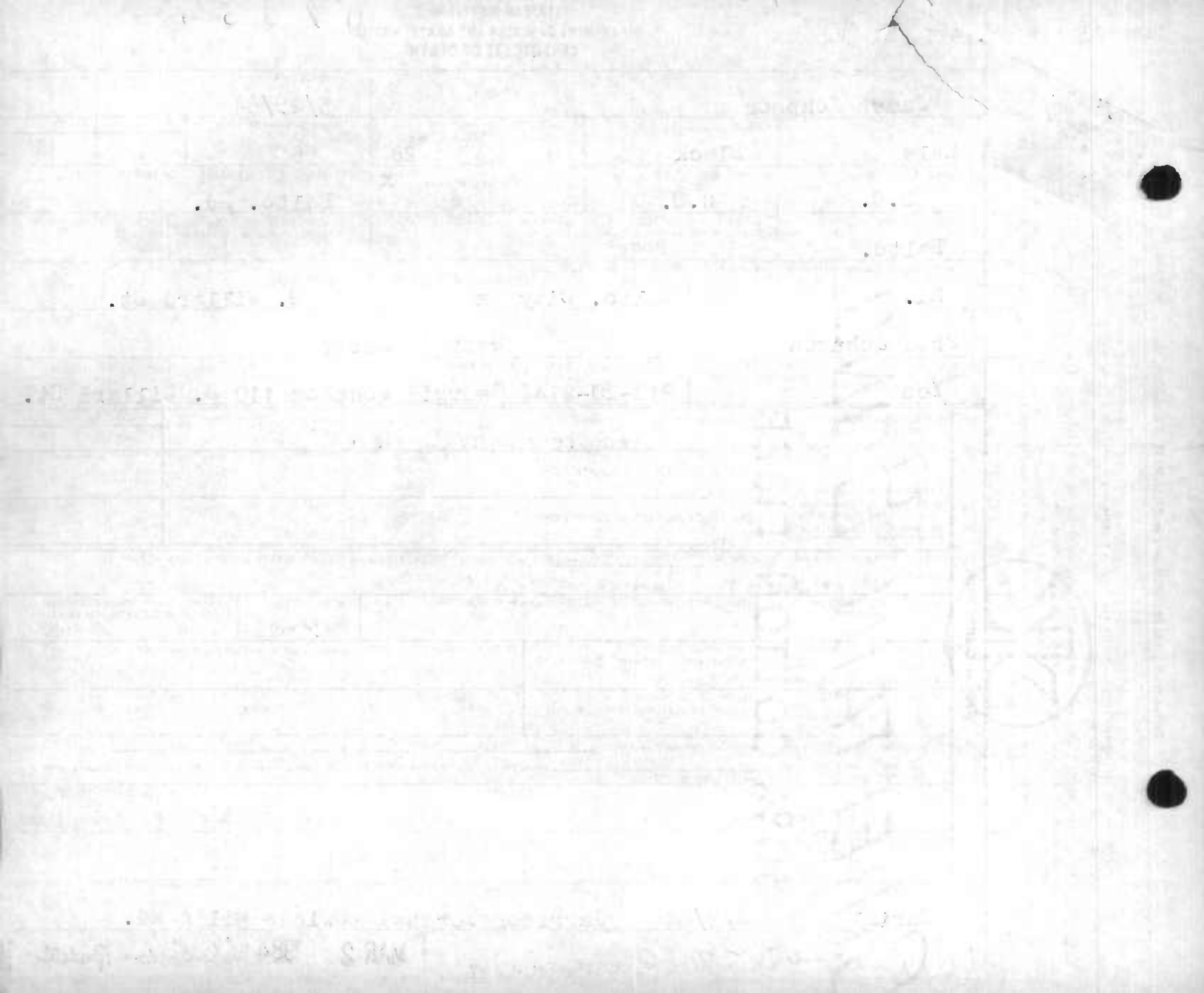
REG. NO.

|   |  |  |  |   |  |  |   |   |  |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Johnson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/29/84</b>                  |   |  | 2b. HOUR<br>M<br><b></b>   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 23 28</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                    |   |   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Md.</b> MD                         |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Home</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |   |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Balto. City</b>   |  | 13c. STREET ADDRESS<br><b>110 S. Willard St.</b>                                     |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fred Johnson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgia Brown</b>   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-20-2144</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Georgia Johnson 110 S. Willard St.</b>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension Angina - stable</b>  |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>fall</b> , 19 <b>82</b> , to <b>2/84</b> , 19 <b></b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>A. Foong MD</b>  |  |  |  |   |  | DEGREE   |   | 22c. DATE SIGNED<br><b>3/30/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. Foong MD</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Univ Md Hosp.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4/2/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest</b>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>R. W. Davidson 2700 Edmondson</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1984</b>                                   |   |   |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                          |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner or the notified physician





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07055

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Johnnie Johnson</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 19 84</b>  |  | 2b. HOUR<br><b>3:19 AM</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>N</b>                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 02 32</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b>  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE<br><b>3422 Chessell Ct. 21226</b>  |   |   |   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Stokes</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hester Johnson</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>YES</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>090-30-3170</b>  |   | 17. INFORMANT<br><b>Tena Johnson</b>   |   |
| 16c. ADDRESS<br><b>3422 Chessell Court</b>  |   |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive cerebral infarct (Lt)</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/19</b> , 19 <b>84</b> , to <b>3/19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |   |   |   |  |   |
| 22b. SIGNATURE<br><b>J Soler</b>  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/19/84</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J Soler</b>   |   | 22e. ADDRESS<br><b>30015 Hanover St. Baltimore, MD</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |   | 23b. DATE<br><b>3/23/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>                        |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b>   |   |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Rendell</b>                                |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
|--|--|---------|--|---|--|-------------------|--|--|--|--|--|--------------------------------------|--|-------|--|----------|--|---|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST              |  | 2a. DATE KNOWN OF DEATH  |  | X <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH                                |  | DAY   |  | YEAR     |  | 2b. HOUR  |  |            |  |
| KEVIN  |  |         |  |   |  | JOHNSON           |  | 3 1 1984   |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY      |  | YEAR  |  | 2d. HOUR   |  |
| Male   |  | Negro   |  | 1 14, 1959  |  | 25                |  | MONTHS   |  | DAYS   |  | HOURS                                |  | MIN.  |  | 3 1 1984 |  |   |  | 12:22 a.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |          |  |   |  |            |  |
| Maryland   |  |         |  | USA   |  |                   |  |  |  |  |  | Baltimore City                       |  |       |  |          |  |   |  |            |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |       |  |          |  |   |  |            |  |
| Baltimore  |  |         |  | Johns Hopkins Hospital  |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |                   |  | 13c. CITY OR TOWN  |  |  |  | 13d. STREET ADDRESS                  |  |       |  |          |  |   |  |            |  |
| Maryland   |  |         |  |   |  |                   |  | Baltimore  |  |  |  | 3220 Dudley Avenue 21213             |  |       |  |          |  |   |  |            |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME  |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| FIRST MIDDLE LAST Charles Cooper   |  |         |  | FIRST MIDDLE LAST Barbara Gilliam   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  | 16b. SOCIAL SECURITY NO.  |  |                   |  | 17. INFORMANT ADDRESS  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| No   |  |         |  | N/A   |  |                   |  | Estelle Johnson 3220 Dudley Avenue   |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |            |  |
| PART 1 DEATH WAS CAUSED BY:  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| IMMEDIATE CAUSE (a) Gunshot wound to head (unspecified weapon)   |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| (c)  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  | 20. AUTOPSY?  |  |            |  |
|  |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
|  |  |         |  | 11:30 a.m. 2-29-1984  |  |                   |  | Subject was shot.  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                   |  | 21i. LOCATION  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
|  |  |         |  | street  |  |                   |  | 800 blk. McKim St., Balto. Md.   |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                   |  | DATE   |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| Ann M. Dixon, M.D.   |  |         |  | Assistant   |  |                   |  | 3-1-84   |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| Ann M. Dixon, M.D.   |  |         |  | 111 Penn St., Balto., Md. 21201   |  |                   |  |  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION                        |  |       |  |          |  |   |  |            |  |
| Burial   |  |         |  | 3/5/84  |  |                   |  | Mt. Zion Cemetery  |  |  |  | Baltimore, Maryland                  |  |       |  |          |  |   |  |            |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  | 25a. DATE REC'D. BY REGISTRAR   |  |                   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                                      |  |       |  |          |  |   |  |            |  |
| Wm. C. March F/H, Inc.   |  |         |  | MAR 05 1984   |  |                   |  | John Davidson  |  |  |  |                                      |  |       |  |          |  |   |  |            |  |

TO: DIRECTOR

FROM: ASST. DIR.



1982 30 JAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

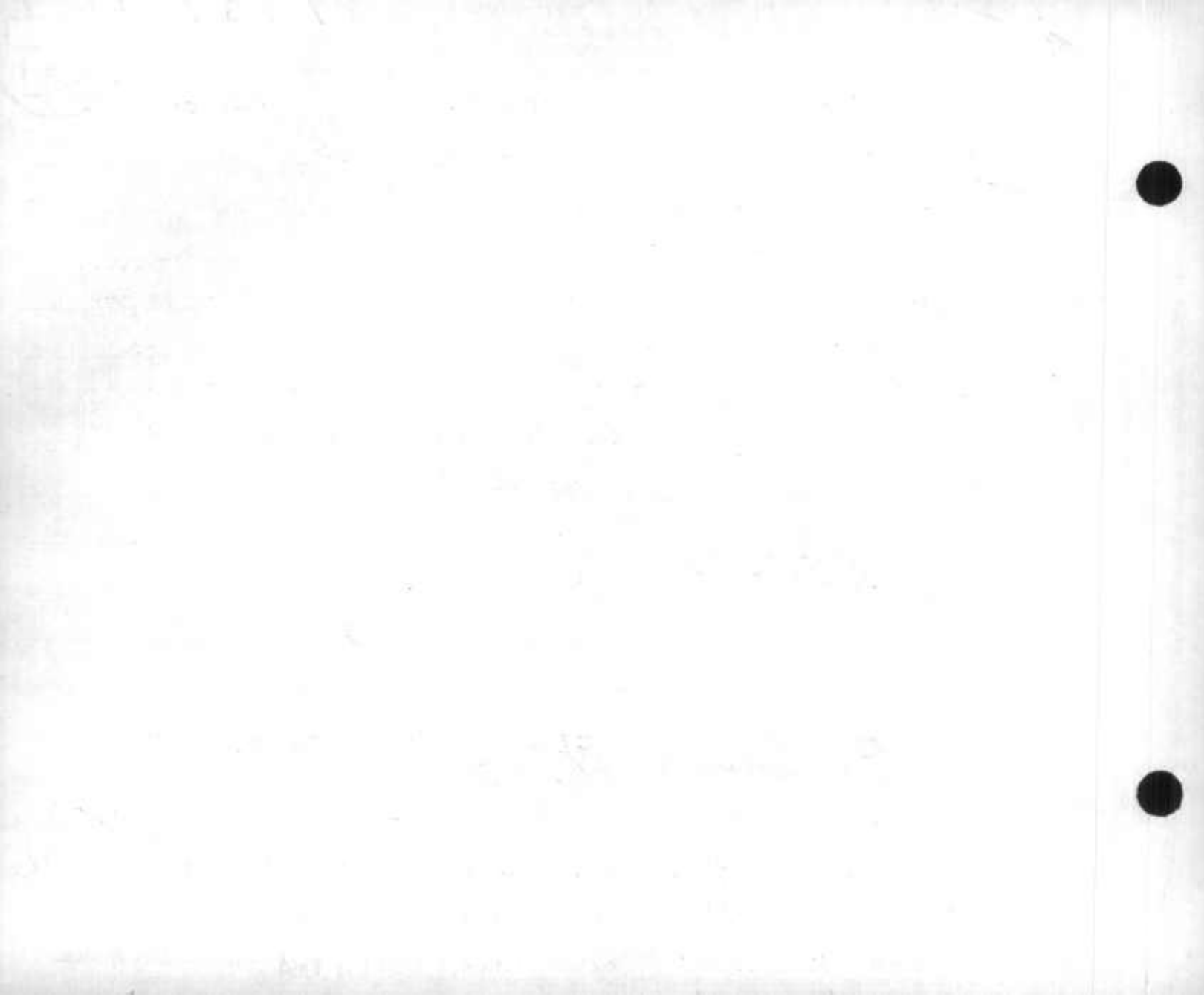
07057

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARTHA W. JOHNSON</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03/08/84</b>                   |  | 2b. HOUR<br><b>4 P M</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02/22/19</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence Toogood</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Toogood</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-26-7560</b>  | 17. INFORMANT ADDRESS<br><b>Samuel P. Johnson 2103 Southern Ave.</b>     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Hepatic Encephalopathy</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b><br><b>Years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Small Bowel Varices</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/13/84</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Feb 14</b> 19 <b>84</b> , to <b>March 8</b> 19 <b>84</b> , that (1) (we) lost<br>saw the deceased alive on <b>March 8</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence Mills</b>   |   | 22c. DEGREE<br><b>MD</b>  |  | 22d. DATE SIGNED<br><b>3/8/84</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAWRENCE MILLS MD</b>   |   | 22f. ADDRESS<br><b>5601 Loch Raven Blvd, Baltimore, Md</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  | 23b. DATE<br><b>3/13/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>        | 23e. DATE REC'D. BY REGISTRAR  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>                      |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |   |  |  |  |

BP



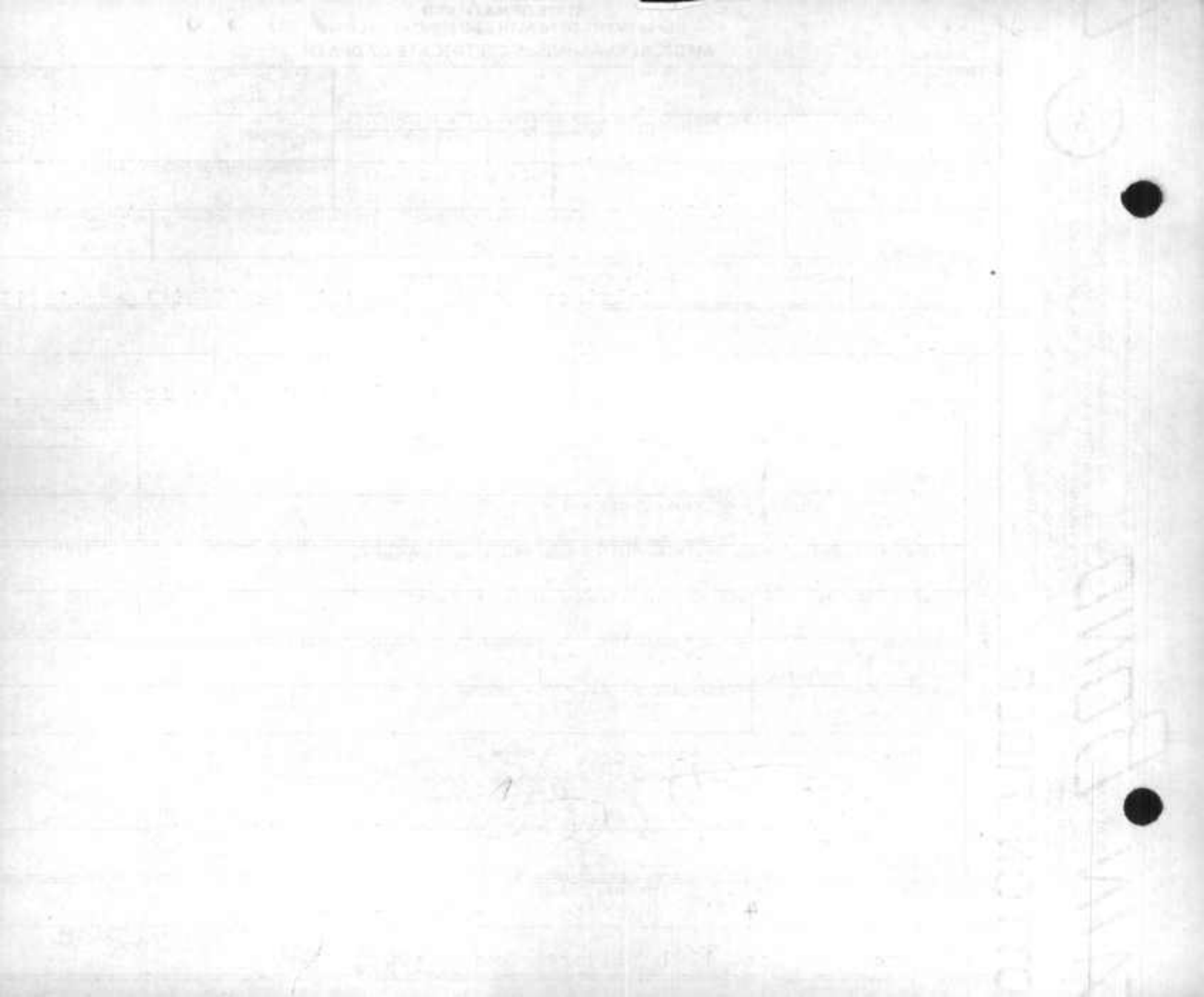
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO.  |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Milton S. Johnson</b>  |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-31 19 84</b> |  |
| 1. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 12 29</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>54</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>3-31 19 84</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>800 blk. Linden Ave. - in auto</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1913 Druid Hill Ave. 21217</b>                            |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Johnson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Hall</b>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Emma Smith 2124 Aiken Street</b>                                    |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b><br><b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |   |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |  |   |  | DATE SIGNED<br><b>3-31-84</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |   |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/4/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E. North Avenue</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                  |  |   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 593

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| 1. FOR STATE REGISTRAR   |  |                  |  |   |  |  |  |  |  | 2. DATE KNOWN OF DEATH                        |  |  |  |                       |  |   |  |                    |  | 3. DATE OF DEATH      |  |  |  |  |  |  |  |  |  |
|--|--|------------------|--|---|--|--|--|--|--|---|--|--|--|-----------------------|--|---|--|--------------------|--|-----------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>PEGGY E. JOHNSON</b>   |  |                  |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>3-15-84</b>        |  |  |  |                       |  |   |  |                    |  | 2b. HOUR <b>11:19</b> |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>B</b> |  | 5. DATE OF BIRTH <b>2 15 37</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>47 YRS.</b> |  | IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b> |  | 2c. DATE PRONOUNCED DEAD <b>3-15-84</b>  |  | 2d. HOUR <b>11:19</b> |  | 2e. MIN. <b>19</b>  |  | 2f. SEC. <b>00</b> |  |                       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                   |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b> |  |  |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD</b>   |  |                  |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                       |  | 13e. STREET ADDRESS <b>1315 N. Bond Street #13</b>        |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Aubery Collins</b>  |  |                  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Olive Collins</b>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>217/30/4109</b>  |  |                       |  | 17. INFORMANT ADDRESS <b>Ray Johnson 1315 N. Bond St.</b> |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Undetermined</b><br><b>7999</b> IMMEDIATE CAUSE (a) <b>Undetermined</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Due to, or as a consequence of</b><br>(c) <b>Due to, or as a consequence of</b>   |  |                  |  |   |  |  |  |  |  |   |  |  |  |                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |  |  |  |  |   |  |  |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |   |  |  |  |  |  |   |  |  |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                  |  | TITLE (SPECIFY) <b>M.D. Assistant</b>   |  |  |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>3-16-84</b>   |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                  |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |   |  |  |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                  |  | 23b. DATE <b>3/19/84</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>   |  |   |  | 23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>MD</b>                                    |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H, Inc.</b> ADDRESS <b>1101 E. North</b>   |  |                  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1984</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randell</b>                                      |  |                       |  |   |  |                    |  |                       |  |  |  |  |  |  |  |  |  |

C. L. A. 100

STATE OF

1000 1000

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Items 5 &amp; 6 mtb 4/6/84 F#590

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT JOHNSON, SR.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 22, 1984</b>                 |   |  | 2b. HOUR<br><b>7:03A</b> M   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 6 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64 63</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POSTAL CLERK</b>                        |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM B. JOHNSON</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY PARRISH</b>         |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>YES</b> |   |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br>ADDRESS<br><b>ROBERT JOHNSON JR. 2620 GROGAN AVE. 21213</b> |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br><b>2762</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metabolic acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>5 days</b> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>chronic obstructive pulmonary disease</b>   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 12, 1984</b> to <b>March 22, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 23, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Patricia A Teares</b> MD  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>3/23/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patricia A Teares</b>  |  |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Dept of Medicine</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>3-27-84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NAT.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>E.L. PHILLIPS 1721 N. MONROE ST.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 28 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Hendall</b>                                     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. When completed, please return it to the funeral director. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07061

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Saint   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/26/84   |   |  | 2b. HOUR<br>1:56 AM  |   |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>AFRO<br>American  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 8 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SO Baltimore General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A   |  |
| 13a. STATE<br>MA   |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Saint  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jones   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>249-34-7488  |  |  | 17. INFORMANT<br>ADDRESS<br>Shirley Price 2717 Spellman Road   |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiovascular collapse / small bowel obstruction<br>1950<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Transitional Squamous Cell Carcinoma head/neck<br>with local metastases<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15.5 hours |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/24/84, 19 84, to 3/26, 19 84, that (I) (we) lost saw the deceased alive on 3/25, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Emmatta Freeman-Pennershaft  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Emmatta Freeman-Pennershaft   |  |  | 22e. ADDRESS<br>SO Baltimore General Hospital.   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>3/31/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co, Md.                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March F/H Inc. 1101 E North Avenue   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1984                                   |  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |  |  |  |   |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |   |   |  |   |  |  |   | REG. NO.   |  |
|---|--|----------------------|---|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES JONES</b>  |  |                      |   |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-14-84</b> |   | 2b. HOUR <b>M</b>  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>Black</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 11 31 53</b>              |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>33</b> YRS.   |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD<br><b>3-16-84</b> 19 <b>4:10A</b>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>851 Woodward</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer Balto City</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY          |   | 13c. CITY OR TOWN<br><b>BALTO</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>851 Woodward St. (30)</b>  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |                      |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>yes</b>  |  |                      |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Carlos Jones 851 Woodward</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>and cirrhosis of liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                      |   |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |   |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |   |  |  |   |  |  |
| 20a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b> |  |   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                          |   |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |   | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  |   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that I took charge of the remains described above. (PARTIAL) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |   |   |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |  |                      |   | TITLE (SPECIFY)<br><b>Assistant</b>                               |  |   |  | DATE SIGNED <b>3-16-84</b>   |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                      |   | ADDRESS <b>111 Penn Street</b>                                    |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                      |   | 23b. DATE<br><b>3-22-84</b>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville VA Cem.</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BROWN'S</b>  |  |                      |   | ADDRESS<br><b>1913 W. BALTIMORE ST</b>                            |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 22 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                   |  |

RECEIVED  
FEBRUARY 1964  
U.S. AIR FORCE



RECEIVED  
FEBRUARY 1964

NOV 1963



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br><b>HERMAN JONES SR.</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 15, 1984</b>   |  | 2b. HOUR P<br><b>7:14 M</b>  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 30 26</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1711 N. Regester St. 21213</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Rochie Jones</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nannie White</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>227-22-6887</b>   |  | 17. INFORMANT ADDRESS<br><b>Helen Jones 1711 N. Regester St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 minutes</b><br><b>1 week</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Chronic obstructive pulmonary disease</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/9/84</b> , 19 <b>84</b> , to <b>3/15</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>M. A. Runge</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUNGE</b>  |  |  |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO. 21205 MD.</b><br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/19/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Balto. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H, Inc. 1101 E. North</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>   |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The following required that the death certificate be signed with the hospital after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial. It is important that the certificate be returned to the State Department of Health and Mental Hygiene within 72 hours after death. If item 21 is checked, the medical examiner must be notified of the death.

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FOR THE PEOPLE OF THE WORLD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO.   |  |                 |  |
|---|--|--|--|---|--|--|--|--|--|--|--|-----------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |  |  | 2b. HOUR        |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Katherine Evelyn Jones</b>  |  |  |  |   |  | <b>3/30/84</b>   |  |  |  |  |  | <b>5 45 P M</b> |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |                 |  |
| <b>Female</b>   |  | <b>White</b>   |  | <b>11 10 1901</b>   |  | <b>82</b>  |  | MONTHS DAYS  |  | HOURS MIN.   |  |                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                       |  |  |  |  |  |                 |  |
| <b>Maryland</b>   |  | <b>U.S.A.</b>  |  |   |  | <b>Baltimore City</b> MD.  |  |  |  |  |  |                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                 |  |
| <b>Baltimore</b>  |  | <b>St. Agnes Hospital</b>  |  |   |  | <b>Housewife</b>   |  | <b>Own Home</b>  |  |  |  |                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |                 |  |
| <b>Maryland</b>   |  | <b>—</b>   |  | <b>Baltimore</b>  |  | <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b> |  | <b>21229 615 Stamford Rd. Baltimore</b>  |  |  |  |                 |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |                 |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST   |  |  |  |  |  |  |  |                 |  |
| <b>James Dunn</b>   |  |  |  | <b>Eleanore Thompson</b>  |  |  |  |  |  |  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |  |  |                 |  |
| <b>No</b>   |  | <b>212-03-6752B</b>  |  | <b>Edwin Jones</b>  |  | <b>615 Stamford Rd. 21229</b>  |  |  |  |  |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast Ca</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>  |  |  |  |   |  |  |  |  |  |  |  |                 |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                 |  |
|   |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |  |  |  |  |  |  |                 |  |
|   |  |  |  |   |  |  |  |  |  |  |  |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |                 |  |
|   |  |  |  |   |  |  |  |  |  |  |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> , 19 <b>84</b> , to <b>3/30</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |  |  |   |  |  |  |  |  |  |  |                 |  |
| 22b. SIGNATURE <b>Ok-Dong Kim Md.</b>   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>3/30/84</b>                                |  |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |                 |  |
|   |  |  |  | <b>800 Catonsville St. St. Agnes Hosp</b>   |  |  |  |  |  |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |                 |  |
| <b>Burial</b>   |  | <b>April 2, 1984</b>   |  | <b>Loudon Park Cemetery</b>   |  | <b>Baltimore MD</b>  |  |  |  |  |  |                 |  |
| 24. FUNERAL DIRECTOR <b>LeRoy &amp; Russell Witzke Funeral Home</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 3 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>                    |  |  |  |  |  |                 |  |
| <b>1630 Edmondson Ave. Catonsville, Md. 21228</b>   |  |  |  |   |  |  |  |  |  |  |  |                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | REG. NO. |              |
|--|--|--|---|----------|--------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |          |              |
| FIRST<br>Louise  |  |  | MIDDLE<br>Jones   |          |              |
| 2. DATE OF DEATH   |  |  | MONTH<br>3  |          | DAY<br>8     |
|  |  |  | YEAR<br>84  |          | 2b HOUR<br>M |
| 3. SEX<br>Female   |  |  | 4. RACE<br>Black  |          |              |
| 5. DATE OF BIRTH<br>MONTH<br>4   |  |  | DAY<br>29   |          | YEAR<br>18   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>65  |  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |          |              |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |          |              |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>448 E. 22nd St.  |          |              |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |          |              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.  |  |  | 13b. COUNTY<br>Balto.   |          |              |
| 14. FATHER'S NAME<br>FIRST<br>Robert   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Eliza  |          |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>230-01-7729   |          |              |
| 17. INFORMANT<br>ADDRESS<br>Passaic, N.J. 07055  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4/100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |          |              |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |          |              |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |          |              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |          |              |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |          |              |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |          |              |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 19 70, to 3-8 19 84, that (I) (we) lost<br>saw the deceased alive on FEB 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |          |              |
| 22b. SIGNATURE<br>Francis X Carmody  |  |  | 22c. DATE SIGNED<br>MAR 10 1984   |          |              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANCIS X CARMODY   |  |  | 22e. ADDRESS<br>3201 N CHARLES ST.  |          |              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3/12/84  |          |              |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., Md.   |          |              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1984  |          |              |
| 1101 E. North Ave.   |  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |          |              |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07066

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |                                   |  |
|---|--|---|---|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET M. JONES</b>    |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>5</b> YEAR <b>84</b> |   |  | 2b. HOUR <b>9<sup>10</sup> A<sup>M</sup></b>   |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>10</b> YEAR <b>14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                    |  |                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>New York</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DEATON MEDICAL CENTER 21201</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |

|   |  |                               |  |  |  |   |  |   |  |  |  |
|---|--|-------------------------------|--|--|--|---|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13a. STATE<br><b>Maryland</b> |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>10 W. Madison St. 21201</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Hutchson</b> LAST <b>Ann</b>        |  |                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ann</b> MIDDLE <b>Westerbird</b> LAST <b>Westerbird</b> |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-2956</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. Chester Jones 10 W. Madison St. 21201</b> |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

**Ce of pancreatic metastases****1579**

DUE TO, OR AS A CONSEQUENCE OF

(b) **SP Wiggles resection**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb-22</b> , 19 <b>84</b> , to <b>March 5</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>March 5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Julian W. Reed M.D.</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/5/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIAN W. REED</b>   |  | 22e. ADDRESS<br><b>611 S. CHAS ST. BALTO. MD. 21208</b>                |  |  |  |   |  |

|   |  |                            |  |   |  |  |  |
|---|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>3/7/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sater Baptist Ch. Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>A. Alan Seitz, Jr.</b>     |  |                            |  | ADDRESS<br><b>3818 Roland Ave. 21211</b>                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>                   |  |
|   |  |                            |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                     |  |

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Second section of handwritten text, continuing the narrative or list.

Third section of handwritten text, showing further details.

Fourth section of handwritten text, located in the lower half of the page.

Bottom section of handwritten text, possibly a signature or conclusion.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                     |  |  | REG. NO.  |  |  |  |
|---|-------------------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE JONES LAST JONES  |                                     |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 21 84   |  | 2b. HOUR<br>9:40 AM  |  |
| 3. SEX<br>F   | 4. RACE<br>B                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 9 27  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UMCC                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                                     |  |  | 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 823 W. SARATOGA ST. 21201 |  |  |  |
| 14. FATHER'S NAME<br>FIRST JOHN MIDDLE LAST MILAMSON  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MATTIE MIDDLE LAST BROWN   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-44-5458   |  | 17. INFORMANT ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ESOPHAGEAL CARCINOMA METS. TO LIVER/BRN</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                     |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br>GASTRIC OUTLET OBSTRUCTION,   |                                     |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 3RD</u> , 19 <u>84</u> , to <u>MARCH 21st</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MAR 21st</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |                                     |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Brayendra P. Singh  |                                     | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>3/21/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRAYENDRA P. SINGH   |                                     | 22e. ADDRESS<br>22 S. GREENE ST. UMCC  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK BY)<br>Burial   |                                     | 23b. DATE<br>3/28/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lissa Men.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balt. County, Md.  |  |
| 24. FUNERAL DIRECTOR<br>C. Cumell 1212  |                                     | 24b. ADDRESS<br>W. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randell  |  |

BP \_\_\_\_\_

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CITY

USA

MD

UNCC

BALTIMORE

323 W. EMBROIDER ST. 21201

BALTIMORE

MD

BROWN

WATTS

MURPHY

JOHN

214-44-252

EXPERIMENTAL CARCINOMA RE-12 TO FIVE

GASTRIC OUTLET RESTRICTION

X

214-44-252

214-44-252

214-44-252

3/21/84

MD

BALTIMORE & JURY

323 W. EMBROIDER ST. UNCC

BALTIMORE & SINGH

MD 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07068

1- FOR  
STATE  
REGISTRAR

|   |  |   |        |   |                       |   |  |  |                       |                                       |  |  |
|---|--|---|--------|---|-----------------------|---|--|--|-----------------------|---------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>NORA</b>  | MIDDLE | LAST<br><b>JONES</b>  | 2a. DATE OF DEATH     |   | MONTH<br><b>8/18/84</b>                            | DAY<br><b>84</b>   | YEAR                  | 2b. HOUR<br><b>12:05A</b>             | MIN.   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |        | 5. DATE OF BIRTH  |                       | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS<br><b>79</b>   |                       | IF UNDER 24 HRS<br>HOURS<br><b>84</b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |                       |                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |        |   |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                       |                                       |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2113 BOLTON STREET 21217</b>   |                       |                                       |  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>THOMAS</b>   |  |   |        | MIDDLE<br><b>E.</b>   | LAST<br><b>LIVERS</b> |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>CARRIE</b> |  | MIDDLE<br><b>BOND</b> | LAST                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |        | 17. INFORMANT<br><b>JOSEPH MADDOX</b>   |                       | ADDRESS<br><b>2113 N. BOLTON ST. 21217</b>  |  |  |                       |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>0389</b> IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |        |   |                       |   |  |  |                       |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |        |   |                       |   |  |  |                       |                                       |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                       |                                       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                       |   |  |  |                       |                                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f. LOCATION<br>STREET<br><b>2113</b>  |                       | CITY OR TOWN<br><b>BALTIMORE</b>  |  | COUNTY<br><b>MARYLAND</b>  |                       | STATE                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/12</b> , 19 <b>84</b> , to <b>8/15</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |        |   |                       |   |  |  |                       |                                       |  |  |
| 22b. SIGNATURE<br><b>Ed Cuen</b>  |  |   |        | DEGREE<br><b>LUTHERAN HOSPITAL</b>  |                       |   |  | 22c. DATE SIGNED<br><b>8/15/84</b>   |                       |                                       |  |  |
| 22d. PHYSICIAN'S NAME, (TYPE OR PRINT)<br><b>EDWINA CUEN</b>  |  |   |        | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>  |                       |   |  |  |                       |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-21-84</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |                       | 23d. LOCATION<br>CITY OR TOWN<br><b>BALTIMORE</b>   |  | COUNTY<br><b>MARYLAND</b>  |                       | STATE                                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS</b>  |  |   |        |   |                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |                       |                                       |  |  |
| ADDRESS<br><b>1721 N. MONROE ST.</b>  |  |   |        |   |                       |   |  |  |                       |                                       |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOTICE

NOTICE

NOTICE

NOTICE

NOTICE

NOTICE



NOTICE



NOTICE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07069

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sarah Jones</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/ 03/ 1984</b>              |   |  | 2b. HOUR<br><b>12:30</b><br>P M  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 24 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b><br>YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1111 Springfield Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Family</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1111 Springfield Ave. Baltimore, Md. 21239</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Jones</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Jackson</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-2729A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Katherine Smith Baltimore, Md. 21239</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Wm. J. Hall</i>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/6/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  | 22e. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/7/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc.<br/>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>F. Davidson-Randall</i>  |  |

BP \_\_\_\_\_

No

212-22-2728

Katherine Smith

Baltimore, Md. 21239

Thomas

Jones

Cora

Jackson

1111 Springfield Ave.

Maryland

Baltimore

X

Ave. Baltimore, Md. 21239

Baltimore

1111 Springfield Avenue

Domestic

Ext. Family

Maryland

U. S. A.

X

Baltimore City

Female

Black

2

24

84

2074

Jones

2/03/ 1984 12:30

Item #7a Film #8590

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07070

1- FOR  
STATE  
REGISTRAR

4/5/84 jp

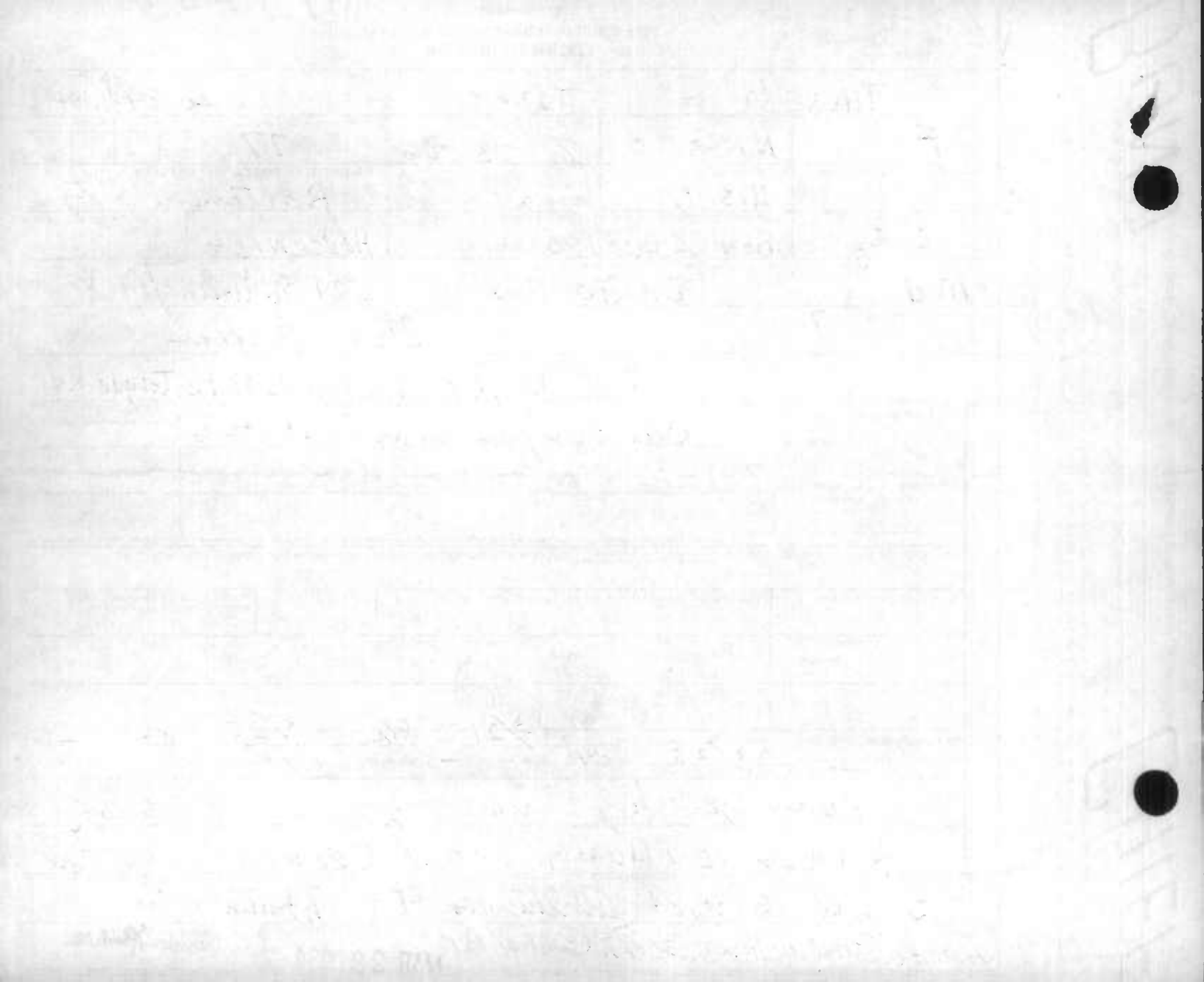
|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THERESA G JONES</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 26 84</b> |   |   | 2b. HOUR<br><b>1:35P M</b>   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 23 06</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>77</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city MD</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>city</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>BON SECOURS</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>521 N. Washington St</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Etha Greene</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sophia Wilson 1503 Pentridge Rd</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Colon with metastasis</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3/21 19 84 3/25 19 84</b>   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/25 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang</b>   |  |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/26/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>  |  |   |  | 22e. ADDRESS<br><b>BON SECOURS Hospital</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/30/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Urbatus MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Locks Funeral Home 1304 N. Central St</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR'S SIGNATURE<br><b>MAR 28 1984</b> |  |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the cause of death must be verified at a post-mortem examination.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie L Jones</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-3-84</b>  |  | 2b. HOUR<br><b>730<sup>pm</sup></b>  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-23-28</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NC</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2909 Joseph Ave. 21225</b>                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Jones</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie Hammond</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217402694</b>   | 17. INFORMANT ADDRESS<br><b>Mary Blackwell 2909 Joseph Avenue</b>                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary</b><br><b>1893</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Widely metastatic Breast Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> , 19 <b>84</b> , to <b>3-3</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased <b>live on 3-3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.                                     |  |  |   |  |  |
| 22b. SIGNATURE<br><b>A. K. Kagan</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED<br><b>3-3-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  | 23b. DATE<br><b>3/9/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 05 1984</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>                           |  |

BP

TOP SECRET

Willie  
male  
NO  
Baltimore  
Baltimore  
Andrew

L  
Black  
U.S.  
Baltimore  
Baltimore  
Jones  
S. H. H. H.

3-3-34  
21  
X Baltimore City  
Hammond

Cardiac Department  
Ward 10

X

OK

3-3-34  
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRISON L. JORDAN</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>6</b> YEAR <b>84</b> 2b. HOUR <b>6:35 P.M.</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>31</b> YEAR <b>08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SMITHFIELD, VA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF-EMP.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>5620 STONINGTON AVE. 21207</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE <b>JORDAN</b> LAST <b>JORDAN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>VIRGINIA</b> MIDDLE <b>JORDAN</b> LAST <b>JORDAN</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>115-07-6818</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>PEARLY JORDAN 5620 STONINGTON AVE.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe COPD - cardiopulmonary</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> , 19 <b>83</b> , to <b>3/6</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence Blotms.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/6/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAWRENCE BLOB</b>  |  |   |  | 22e. ADDRESS<br><b>6615 Reisterstown Rd.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/10/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b> ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>  |  |



10

NOV 1962

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

(12)

CHIEF

2050 EBL

100-100000-1000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

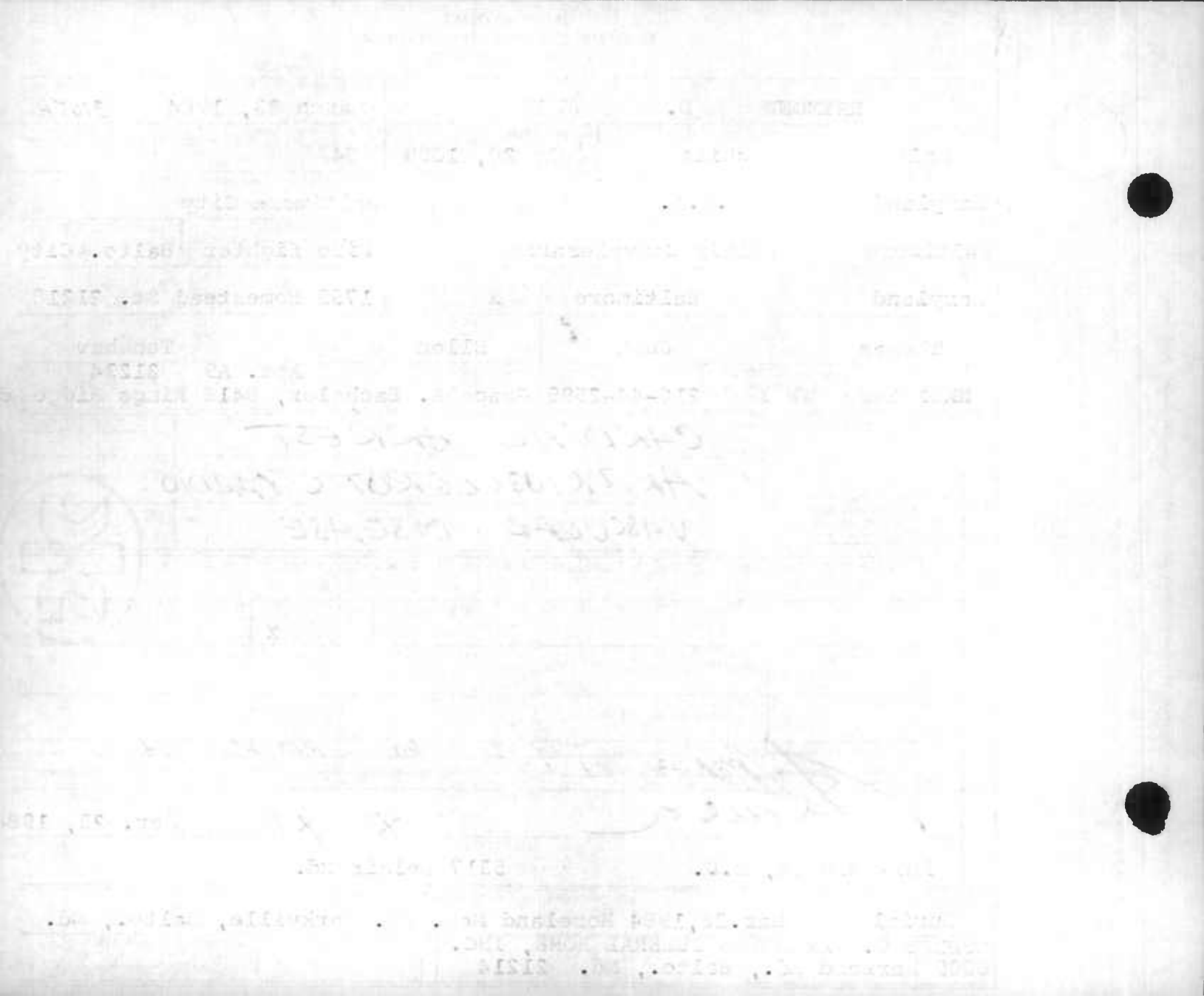
|  |  |  |  |   |   |  |   |  |
|--|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RAYMOND D. JUBB</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23, 1984</b> |   | 2b. HOUR<br><b>3:05 A.M.</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 20, 1899</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>   |   |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Convalesarium</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fire fighter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Jubb</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Tenshaw</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>XXXX Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>WW 1 216-44-2599</b>  |   |  |
| 17. INFORMANT<br><b>Grace A. Bachelor</b>  |  | 18. ADDRESS<br><b>Apt. A9 21234</b>  |  | 19. CITY OR TOWN<br><b>8418 Kings Ridge Rd</b>  |   | 20. STATE<br><b>Baltimore</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIO-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <b>VASCULAR DISEASE</b> |  |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 23, 1980</b> to <b>MAR. 23, 1984</b> , that (I) (we) last saw the deceased at <b>Mar 23, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) (after death).  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Rivera</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>Mar. 23, 1984</b>  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luis Rivera, M.D.</b>  |  | 22e. ADDRESS<br><b>5317 Belair Rd.</b>   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 26, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto., Md.</b>  |   |  |
| 24. DIRECTOR OF ROBERT O. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>  |   | 25. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |   |  |  |   |  | REG. NO. |  |
|---|-------------------------|---|--|---|---|--|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph S. Kaffl, Sr.</b>   |                         |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 24 1984</b> |  | 2b. HOUR <b>M</b>                                       |  |          |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 2, 1919</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                        | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br><b>3 24 1984</b>   |  | 2d. HOUR <b>4:16</b> <b>A</b>                           |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                       |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5859 Arizona Avenue.</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tool &amp; Die Maker</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen. Motors</b> |  |          |  |
| 13a. STATE<br><b>Maryland</b>   |                         |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph S. Kaffl</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Krescenzia Niggl</b> |   |   | 13e. STREET ADDRESS<br><b>5859 Arizona Ave Balto Md 21206</b>  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>219-34-0490</b>                           |   | 17. INFORMANT ADDRESS<br><b>Mrs. Gertrude Kaffl 5859 Arizona Ave 21206</b>    |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |  |   |   |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)              |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |  |   |  |          |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>                                      |   |   | MEDICAL EXAMINER   |  | DATE SIGNED <b>3/24/84</b>                              |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                         |   | ADDRESS<br><b>111 Penn St. Balto., MD.</b>                               |   |   |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |                         |   | 23b. DATE<br><b>Mar. 26, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cemetery</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                          |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc</b>   |                         |   | ADDRESS<br><b>5305 Harford Rd.</b>                                       |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1984</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                                  |   |  |          |  |

1992-93-94

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07075

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER P KAHLER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 3, 1984</b>                                     |  | 2b. HOUR<br><b>01:14am</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br><b>10-25-1909</b> YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74 yrs.</b>                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>American Dredging Co.</b>  |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>635 N. Robinson St. 21205</b>                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Kahler</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Bell</b>                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-2147</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Marie Kahler 635 N. Robinson St. 21205</b>            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Pneumothorax (spontaneous)</b><br>4920<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Emphysema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12:00 am</b> , 19 <b>84</b> , to <b>1:14 am</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>H. Aoun</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>3/3 am</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Aoun</b>   |  | 22e. ADDRESS<br><b>JHH</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-6-84</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |
| 24. FUNERAL DIRECTOR<br><b>Schimmek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Baltimore, Md. 21213</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>                                   |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |  |

RELEASED NON-MEDICAL DR. KAUFFMAN PER MR. HENRY

MEDICAL CERTIFICATION





BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or item 18 is not marked, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |   |  |
|--|--|---|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO. 07076  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSA KAIRIS   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3/10/84   |   |  | 2b. HOUR<br>1040 PM                       |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>08 03 02   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MARYLAND --- BALTIMORE   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>607 S. BEECHFIELD AVENUE, 21229   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CARL LEICHTNER  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELSIE TJARKS |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-52-3564  |  | 17. INFORMANT ADDRESS<br>ELMER T. MOONEY 607 S. BEECHFIELD AVENUE 21229   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain anoxia</u><br>9120<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Respiratory &amp; cardiac arrest (RESUS)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>aspiration of emesis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Hx of diverticulitis pt arrived in ER &amp; tense probably surgical abdomen</u>   |  |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>84</u> to <u>3/10</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Andrew Gordon MD</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br>3/11/84               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andrew GORDON MD  |  |   |  | 22e. ADDRESS<br>SAINT AGNES Hosp.<br>900 Caton Ave Baltimore  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>03-14-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN BALTIMORE MARYLAND     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 12 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                          |  |   |  |



3/10/54

Department of Agriculture  
(1954)

2/10/54

1954

U.S. EN

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07071

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>George J Kalkanis                                    |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 09 84                               |   | 2b. HOUR<br>2:00 PM   |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 09 00  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greece   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.              |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chad Samaritan |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waiter |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Del. |   |   | 13b. COUNTY<br>✓   | 13c. CITY OR TOWN<br>Wilmingon                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Kalkanis   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Keriakoula Milonakos      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                    |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-03-6765 A  |  | 17. INFORMANT ADDRESS<br>Mrs. Pauline Prevas 5320 Holder Ave. |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2030

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

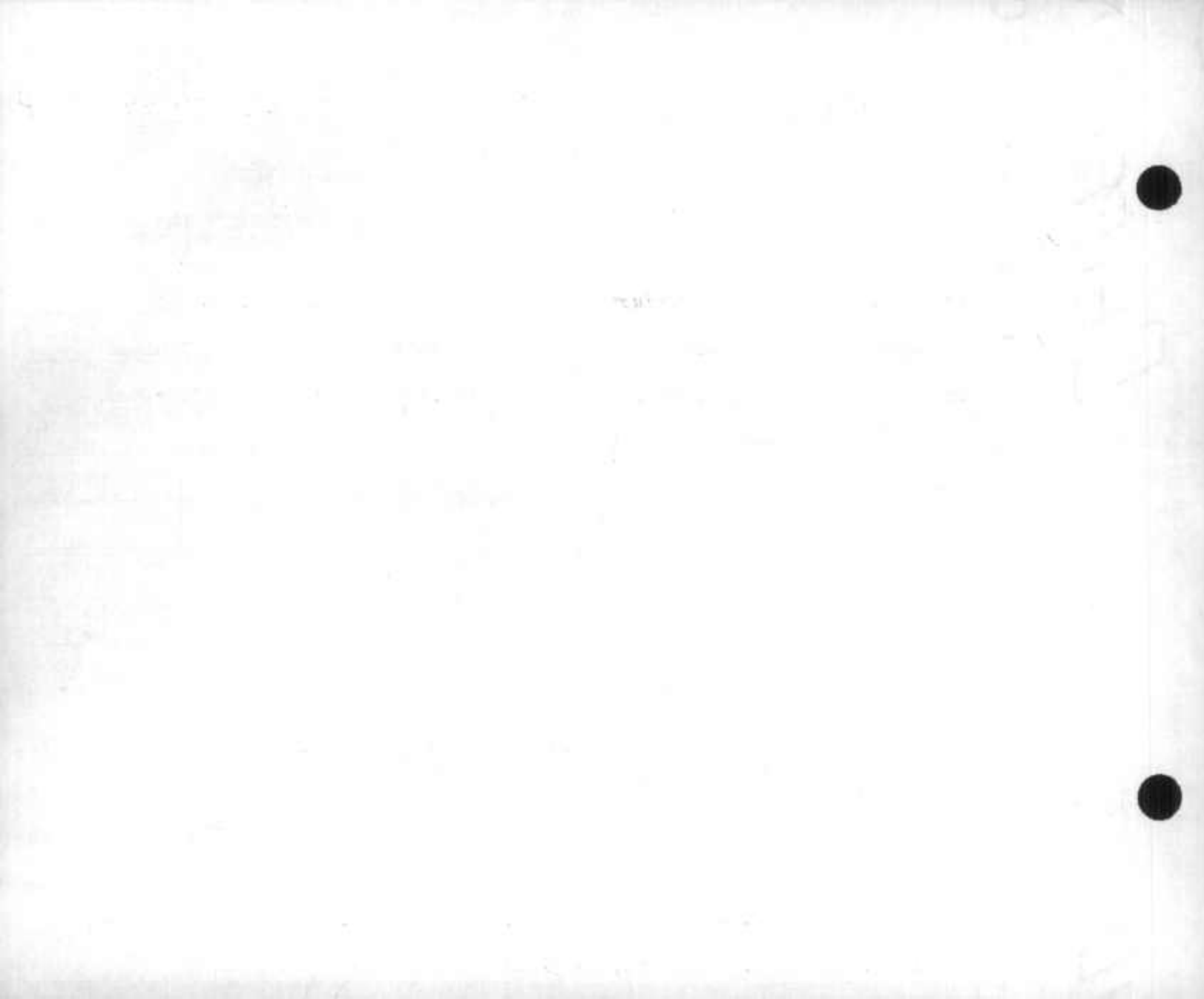
|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-4-1984, to 3-9-1984, that (I) (we) lost<br>saw the deceased alive on 3-9-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Shanida Siddiot   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>3-9-84   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHANIDA SIDDIOT  |  | 22e. ADDRESS<br>9814   |   |

|  |                            |  |   |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                           | 23b. DATE<br>Mar. 12, 1984 | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Ortho. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Balto, Md. |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck Inc. Baltimore, Maryland |                            |  | 25a. DATE REC'D BY REGISTRAR<br>MAR 13 1984                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07078

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIA KARAGIORGE                    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 13 84 |   |  | 2b. HOUR<br>20 <sup>00</sup> AM   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 02 98  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CYPRUS                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Cyprus  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GEN HOSP |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALT   |  | 13c. CITY OR TOWN<br>BALT   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AMOUS                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELEN HAJIAN TONI  |  | 16. STREET ADDRESS / ZIP CODE<br>323 TRAPE RD 21222   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-54-3297  |  | 17. INFORMANT<br>chart  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Cardiovascular

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

disease,

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>3/13  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>— 3/6 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>84 3/12 84                      |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13 19 84, to 3/13 19 84; that (I) (we) last saw the deceased alive on 3/13 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Dendros MD  |  |   |  | DEGREE<br>—  |  | 22c. DATE SIGNED<br>3/13/84 2 <sup>00</sup> PM  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS<br>813 E.H.   |  |   |  |

|   |  |                      |  |  |  |   |  |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                    |  | 23b. DATE<br>3-15-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Nicholas T. Matthews, 3021 Eastern Ave.<br>Baltimore, Md. |  |                      |  | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE<br>MAR 15 1984 Julia Davidson-Rendell |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the files after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpages, Pages 1 and 2, and fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 11 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lillian A. Karp   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/30/84<br>2b. HOUR<br>130 AM |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 26 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>--   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Balto, Md. 21214<br>2831 Montebello Terrace,  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jerome Karp   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Rich  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-01-6444  |  | 17. INFORMANT<br>ADDRESS<br>Balto, Md. 21206<br>Sharon Edwards, 5610 Gardenville Ave.           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5850 CHRONIC RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>GASTROINTESTINAL BLEEDING   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/16 19 84 to 3/30 19 84, that (I) (we) last saw the deceased alive on 3/30 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 23. SIGNATURE<br>[Signature]<br>23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William S. Starnato  |  |   |  |   |  | 23b. ADDRESS<br>Mercy Hospital Balto  |  | 23c. DATE SIGNED<br>3/30/84  |  |
| 23d. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23e. DATE<br>4/2/84  |   | 23f. NAME OF CEMETERY OR CREMATORY<br>Garden of Faith                |   | 23g. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHIMUNEK FUNERAL HOME, 3331 BREHMS LA, 21213   |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>3 1984  |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |   |  |   |  |  |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 07080

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN ALBERT KASSAKATIS, SR</b>          |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 15 84</b> |   |  | 2b. HOUR<br>M<br><b>7:15 P</b>  |  |   |  |
| 3. SEX<br><b>Male M</b>   |  | 4. RACE<br><b>White W</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 2 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST Agnes Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired U.S. Coast Guard</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Violtville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  | 13e. STREET ADDRESS<br><b>3626 Coolidge Ave., 21229</b>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late Leonard Kassakatis</b>          |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Carol Salzmann</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>212 09 5456</b>  |   | 17. INFORMANT ADDRESS<br><b>William R Kassakatis 3704 5th Ave Edgewater Md 21037</b>  |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Bronchopneumonia**  
1629  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Metastatic carcinoma, lung**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

**Perforated colonic diverticulum and peptic ulcer, stomach & peritonitis**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>84</b> to <b>3/15</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>William J Hicken MD</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/16/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W J HICKEN MD</b>   |  |  |  | 22e. ADDRESS<br><b>St Agnes Hospital</b>   |  |   |  |

|  |  |                                  |  |  |  |   |  |
|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                   |  | 23b. DATE<br><b>March 20 '84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harry H Witzke 4112 Columbia RD Ellicott City</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>      |  | 25b. REGISTRAR'S SIGNATURE<br><i>John S. ...</i>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the funeral director, this certificate must be notified of once.

BP

HARRY H. WHITE, 1112 Columbia Rd. Ellsboro City

Baltimore Maryland

London Park

March 20, 84

Gurial

late Leonard Kasankalis 212 09 2450 William R Kasankalis 3704 5th Ave Riverston Md 21037

late Carol Salzman

3630 Coolidge Ave..

Baltimore Md. Whiteville

Baltimore St Agnes Hospital

Retired U.S. Coast Guard

Baltimore City

Maryland U.S.A.

x

Male White

REG. NO.

7  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83  
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3 of this certificate, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18, 19, or other traumatic event, or other traumatic event, the medical examiner's office must be notified at once.

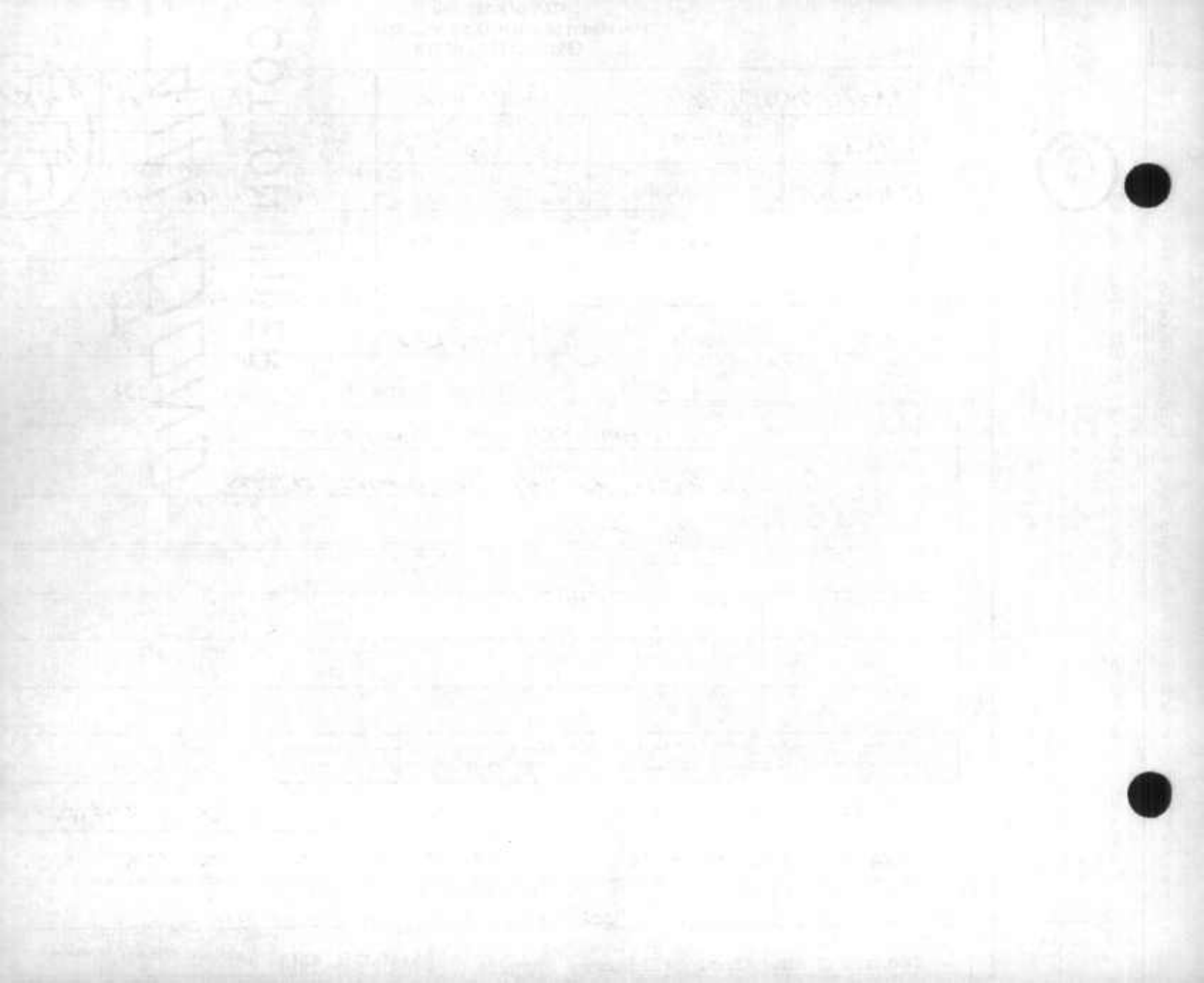
BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dawn Marie Keene</b>  |  | 2a. DATE OF DEATH<br>MONTH YEAR DAY 3 18 84   |  | 2b. HOUR<br>9:27 P.M.   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 3 18 84  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSP.                         |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                              |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Keene   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DORCA PRICE  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |
| 17. INFORMANT<br>Robert Keene  |  | 18. SOCIAL SECURITY NO.<br>None   |  | 19. ADDRESS<br>Same As 13e  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>7651<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE PNEUMONIA / RESPIRATORY DISTRESS</b><br>8440.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HEMORRHAGE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |  |
| 21a. DATE OF OPERATION   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21e. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |
| 21g. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21h. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |  |   |  |
| 22a. SIGNATURE<br><i>Thelma Anderson, MD</i>   |  | 22b. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/19/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MA. ROSARIO P. AMOS   |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITALS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/20/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rock Springs Episcopal Forest Hill Harford Md                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 22 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 (ATTACH PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |   |   |   |   |  |                        | REG. NO.   |  |               |
|--|------------------|--|--|---|---|---|---|--|------------------------|--|--|---------------|
| 1. FOR STATE REGISTRAR   |                  |  |  |   |   |   |   |  |                        |  |  |               |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>John L. Keene   |                  |  |  |   |   |   |   |  |                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>3-27 1984 |  | 2b. HOUR<br>M |
| 3. SEX<br>male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 13 23  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.                                    | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>3-27 1984                       |  | 2d. HOUR<br>11:22 a. M |  |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |                        |  |  |               |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |  |               |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |  |   |   |   |   |  |                        |  |  |               |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>802 Abbott Court 21202  |                        |  |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lewis E. Keene   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucinda M. Flemmings  |  |   |   |   |   |  |                        |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |                  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>219-16-5175                                       |   | 17. INFORMANT ADDRESS<br>Walter J. Keene 3022 Rosalind Ave.                                     |   |  |                        |  |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |  |  |   |   |   |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |   |   |   |  |                        |  |  |               |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |   |   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |  |  |               |
| 20a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |  |                        |  |  |               |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |   |  |                        |  |  |               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |   |   |  |                        |  |  |               |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                  | TITLE (SPECIFY)<br>Assistant   |  | M.D. MEDICAL EXAMINER   |   |   |   | DATE SIGNED<br>3-28-84   |                        |  |  |               |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |                  | ADDRESS<br>111 Penn Street   |  |   |   |   |   |  |                        |  |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |                  | 23b. DATE<br>4/2/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA                      |   |   |   | 23d. LOCATION<br>Owing Mills, COUNTY Md. STATE                                       |                        |  |  |               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |                  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1984  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                          |                        |  |  |               |

RECEIVED BY THE DIRECTOR OF THE  
BUREAU OF THE ARMY AND NAVAL  
DEPARTMENT OF THE ARMY AND NAVAL  
DEPARTMENT OF THE ARMY AND NAVAL

1000 P. S. HAN

PHOTOGRAPHED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

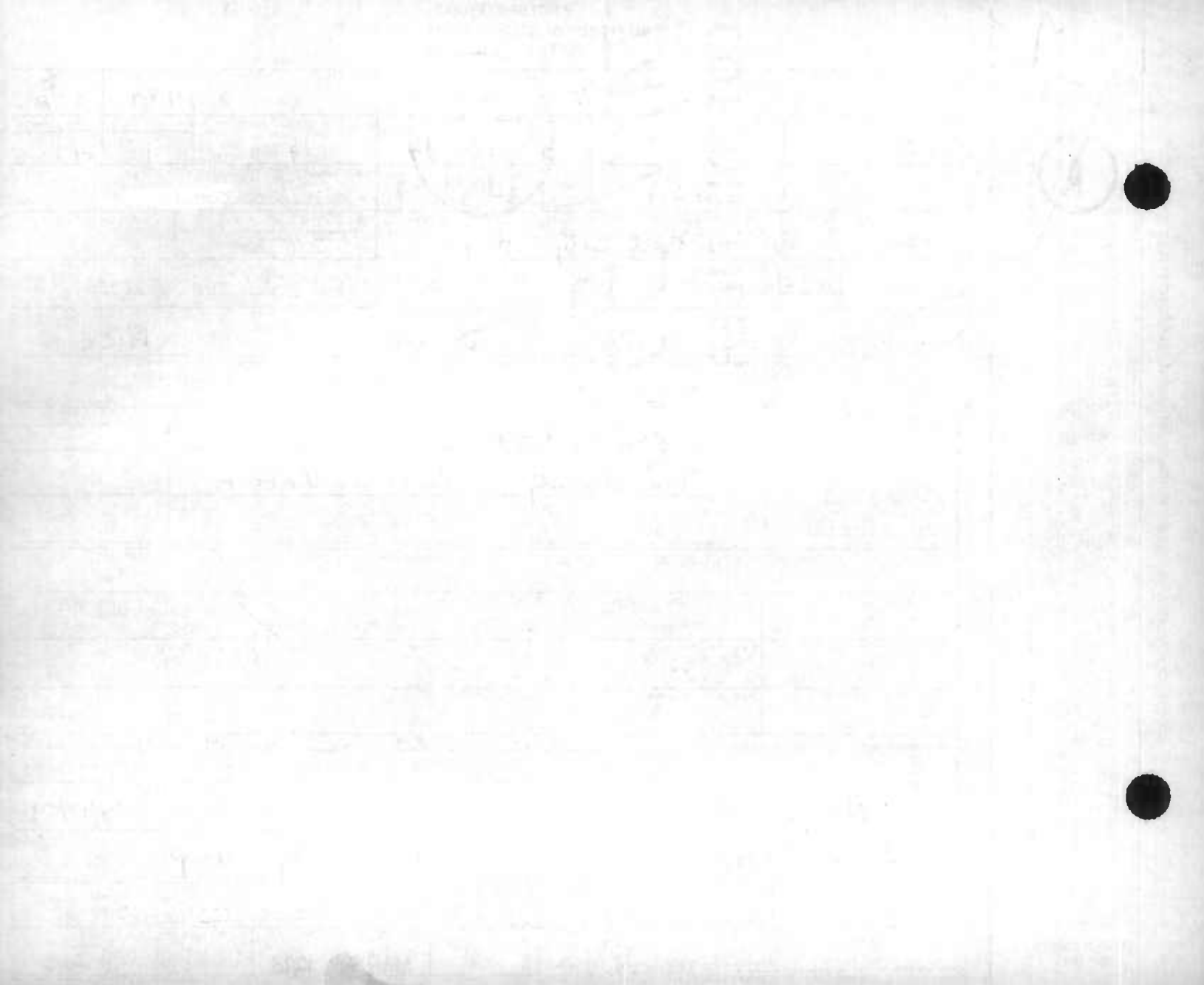
REG. NO.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>Tina Marie Keene  |   | MONTH DAY YEAR<br>3 19 84  |   | 3 50 A M   |  |
| 1 SEX  | 4. RACE   | 5. DATE OF BIRTH   |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |
| Female   | White   | MONTH DAY YEAR<br>3 18 84  |   | 14 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland   | USA   |  |   | Baltimore MD.  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OR SPECIFY IF NOT OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Essex  | Balt. City Harp.  |  | None  |  |  |
| 13a. STATE   |   |  | 13b. INSIDE CITY LIMITS?  |  |  |
| Maryland   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |
| 13c. STREET ADDRESS  |   |  | 21236   |  |  |
| 4100 India Ave   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |  |
| Robert Tina Marie Keene  |   | Debra Price  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
| No   |   | -----  |   | Mr Robert Keene Same As 13c  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio - Resp arrest<br>7651<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Prematurity, Pneumo thorax.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-18-1984, to 3-19-1984, that (I) (we) lost saw the deceased alive on 3-19-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>Ranjana .M.D.  |   | DEGREE   |   | 22c. DATE SIGNED<br>3/19/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. RANJAN   |   | 22e. ADDRESS<br>Balt. City Harp.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |   | 3/20/84  |   | Rock Springs Episcopal   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   | 23e. DATE REC'D. BY REGISTRAR  |   | 23f. REGISTRAR'S SIGNATURE   |  |
| Forest Hill Harford Md   |   | MAR 22 1984  |   | Julia Davidson-Randall   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |   | 24a. DATE REC'D. BY REGISTRAR  |   | 24b. REGISTRAR'S SIGNATURE   |  |
| Leonard J Ruck Inc. Baltimore, Maryland  |   |  |   |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to arrive.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07085

1- FOR  
STATE  
REGISTRAR

REG. NO.

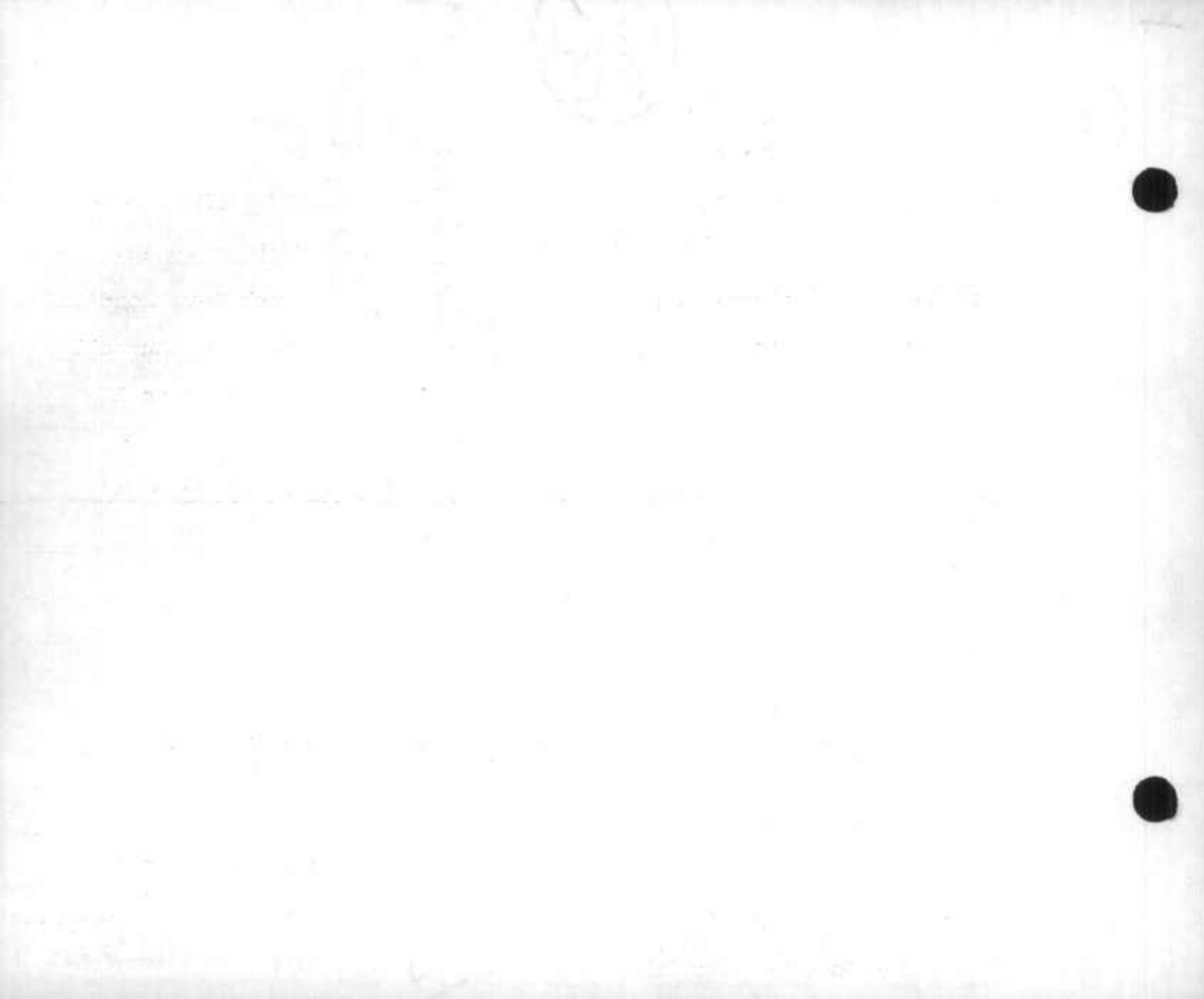
|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DORSEY D. KEIM   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/13/84                         |   |  | 2b. HOUR<br>6:40a M   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 28 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER BALTO MD |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Edgemere   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7844 North Cove Road 21219   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Earl Keim   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha R. Russell  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II   |  |  |  | 16b. SOCIAL SECURITY NO.<br>218 07 4083   |  | 17. INFORMANT<br>ADDRESS<br>Ruby A. Keim Same as 13e  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>4449<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>extreme cardiomyopathy 2° previous cardiac arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>systemic emboli s/p CVS seizure disorder</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                    |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Jan. 18</u> , 19 <u>84</u> , to <u>March 13</u> , 19 <u>84</u> , that (X) (we) lost saw the deceased alive on <u>March 13</u> , 19 <u>84</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE  |  |  | 22c. DATE SIGNED   |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KMETZO   |  |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto Md. 4218                   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3/16/1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Avenue<br>ADDRESS Dundalk, MD. 21222  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1984<br>25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |   |
|---|--|--|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JEROME HOWARD KELLY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-5-84</b>  |  |  | 2b. HOUR<br><b>4:21 P.M.</b>   |  |   |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 27, 1906</b>   |  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |  | 8. IF UNDER 24 HRS.  |  |   |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  | 14. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |   |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>Maryland</b>  |  |  | 15b. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 15c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Kelly</b>  |  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Kelly</b>  |  |  | 18. STREET ADDRESS / ZIP CODE<br><b>5935 Falkirk Rd. 21239</b>   |  |   |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 19b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 217-05-5164</b>   |  |  | 20. INFORMANT<br>ADDRESS<br><b>Rita M. Marsiglia Forest Hill, Md.</b>  |  |   |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRADY CARDIA &amp; ARRHYTHMIAS, &amp; HYPOTENSION.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS &amp; RENAL FAILURE &amp; SEMI.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>RIGHT HIP FRACTURE</b>                                |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SIADH, HISTORY OF CVA X2, DIABETES MELLITUS</b>  |  |  |   |  |  |  |  |   |
| 22a. DATE OF OPERATION<br><b>1/7/84 &amp; 2/1/84</b>  |  |  | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FRACTURED @ HIP</b>  |  |  | 22c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |
| 23a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 23b. TIME OF INJURY<br>HOUR (A.M.) MONTH DAY YEAR<br><b>11:33 P.M. 1-6 1984</b>   |  |  | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>PATIENT FELL IN THE SHOWER</b>  |  |   |
| 24a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |  | 24b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>HOME</b>   |  |  | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5935 FALKIRK RD. BALTO. MD. 21239</b>  |  |   |
| 25. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> , 19 <b>84</b> , to <b>March 5<sup>th</sup></b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |
| 26. SIGNATURE<br><b>Jean K. Janda M.D., M.P.H.</b>  |  |  |   |  |  | 27. DEGREE<br><b>M.D., M.P.H.</b>  |  | 28. DATE SIGNED<br><b>3/5/84</b>                |
| 29. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEAN K. JANDA M.D., M.P.H.</b>   |  |  |   |  |  | 30. ADDRESS<br><b>UNION MEMORIAL HOSPITAL<br/>BALTIMORE, MD.</b>   |  |   |
| 31. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 32. DATE<br><b>Mar. 9, 1984</b>   |  |  | 33. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  |   |
| 34. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>  |  |  | 35. ADDRESS<br><b>6500 York Rd.</b>   |  |  | 36. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and capably filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 70. DATE OF DEATH MONTH DAY YEAR                               |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 70. DATE OF DEATH MONTH DAY YEAR                               |  |  |  |
| 2. SEX  |  |  |  | 71. HOUR   |  |  |  |
| 3. RACE   |  |  |  | 72. AGE (IN YEARS LAST BIRTHDAY)                               |  |  |  |
| 4. DATE OF BIRTH MONTH DAY YEAR   |  |  |  | 73. IF UNDER 1 YEAR  |  |  |  |
| 5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  | 74. IF UNDER 24 HRS  |  |  |  |
| 6. CITIZEN OF WHAT COUNTRY?   |  |  |  | 75. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  | 76. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |
| 8. CITY OR TOWN OF DEATH  |  |  |  | 77. KIND OF BUSINESS OR INDUSTRY                               |  |  |  |
| 9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  | 78. STREET ADDRESS / ZIP CODE                                  |  |  |  |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 79. INSIDE CITY LIMITS?  |  |  |  |
| 11. STATE   |  |  |  | 80. MOTHER'S MAIDEN NAME                                       |  |  |  |
| 12. COUNTY  |  |  |  | 81. ADDRESS  |  |  |  |
| 13. CITY OR TOWN  |  |  |  | 82. DATE SIGNED  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 83. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 15. EMITT KERSEY  |  |  |  | 84. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  | 85. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 17. YES   |  |  |  | 86. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 18. SOCIAL SECURITY NO.   |  |  |  | 87. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 19. 237-22-0981   |  |  |  | 88. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20. INFORMANT   |  |  |  | 89. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21. THELMA SAUNDERS   |  |  |  | 90. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 22. 751 DRUID LAKE DRIVE  |  |  |  | 91. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  | 92. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 24. PART I. DEATH WAS CAUSED BY:  |  |  |  | 93. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 25. IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  |  |  |  | 94. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 26. DUE TO, OR AS A CONSEQUENCE OF  |  |  |  | 95. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 27. SQUAMOUS CELL CARCINOMA of LUNG   |  |  |  | 96. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 28. AND NECK AND  |  |  |  | 97. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 29. ADENOCARCINOMA OF LEFT MAXILLARY MASS   |  |  |  | 98. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 30. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  | 99. YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 31. DATE OF OPERATION   |  |  |  | 100. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 32. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 101. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 102. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  |  | 103. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 35. P.M. 19   |  |  |  | 104. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 36. INJURY OCCURRED   |  |  |  | 105. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 37. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 106. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 38. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  | 107. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 39. I certify that (I) (this hospital) attended the deceased from 2-4-84, 19 84, to 3-20-19 84, that (I) (we) last saw the deceased alive on MARCH 7, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  | 108. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 40. SIGNATURE   |  |  |  | 109. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 41. DOROTHY SNOW, M.D.  |  |  |  | 110. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 42. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 111. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 43. ADDRESS   |  |  |  | 112. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 44. V.A. MEDICAL CENTER BALD  |  |  |  | 113. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 45. 3900 LOCH RAVEN BLVD. MD 21218  |  |  |  | 114. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 46. BURIAL, CREMATION, REMOVAL  |  |  |  | 115. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 47. DATE  |  |  |  | 116. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 48. NAME OF CEMETERY OR CREMATORY   |  |  |  | 117. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 49. GARRISON FOREST VA  |  |  |  | 118. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 50. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  | 119. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 51. OWINGS MILLS, MD.   |  |  |  | 120. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 52. FUNERAL DIRECTOR  |  |  |  | 121. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 53. NAME ADDRESS  |  |  |  | 122. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 54. WM C MARCH F/H INC, 1101 E NORTH AVENUE   |  |  |  | 123. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 55. DATE REC'D BY REGISTRAR   |  |  |  | 124. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 56. REGISTRAR'S SIGNATURE   |  |  |  | 125. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 57. J. W. WATSON - HANDELL  |  |  |  | 126. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

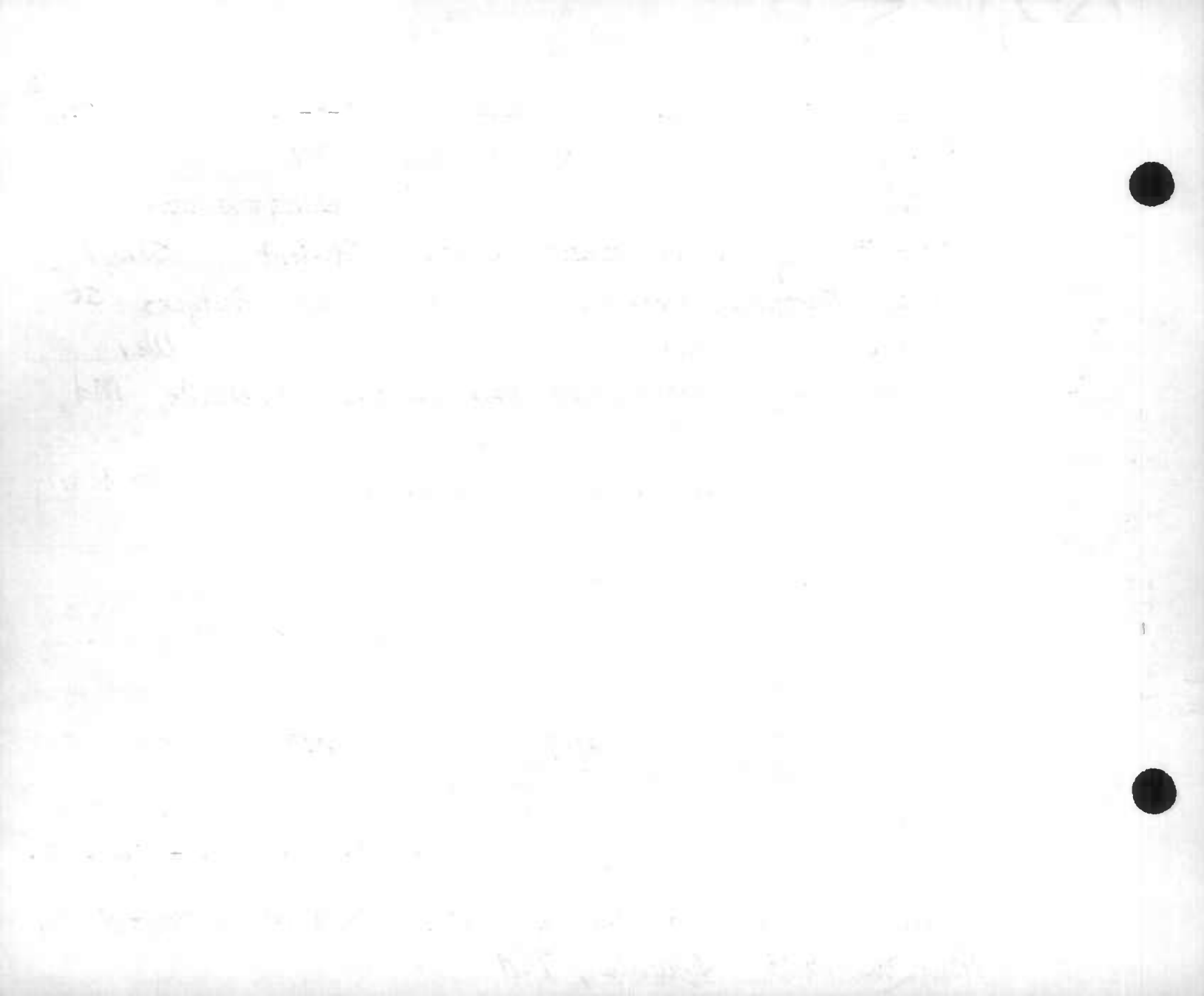
07088

REG. NO.

|  |  |   |  |   |        |   |                   |                                |     |                    |          |   |
|--|--|---|--|---|--------|---|-------------------|--------------------------------|-----|--------------------|----------|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH | MONTH                          | DAY | YEAR               | 2b. HOUR | A |
|  |  | MARY  |  | M.  |        | KIANG   | 3-6-84            |                                |     |                    | 2:30     | M |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |                   | IF UNDER 1 YEAR                |     | IF UNDER 24 HRS    |          |   |
| Female   |  | White   |  | Nov. 2, 1956  |        | 27  |                   | MONTHS                         |     | DAYS               |          |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                   |                                |     |                    |          |   |
| Taiwan   |  |   |  |   |        | BALTIMORE CITY  |                   |                                |     | MD.                |          |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |        | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                   |                                |     |                    |          |   |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL  |  | Student   |        | School  |                   |                                |     |                    |          |   |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS / ZIP CODE |     |                    |          |   |
| Md.  |  | Montgomery  |  | Rockville   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |                   | 508 Rutgers                    |     | 20838              |          |   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |        | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT                  |     | ADDRESS            |          |   |
| John   |  | Kiang   |  | No  |        | 579 82 5681   |                   | Marty Taglier                  |     | Rockville, Md.     |          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                         |  | 19. DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |  | 20. DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                   |                                |     |                    |          |   |
| 1550   |  | Respiratory Arrest  |  | Hepatocellular Carcinoma  |        | 15 minutes  |                   |                                |     |                    |          |   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  |   |  |   |        | 10/83 to 3/84   |                   |                                |     |                    |          |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                      |  | Hepatocellular Carcinoma  |  |   |        |   |                   |                                |     |                    |          |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                             |                   |                                |     |                    |          |   |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |                   |                                |     |                    |          |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |        |   |                   |                                |     |                    |          |   |
|  |  | P.M. 19   |  |   |        |   |                   |                                |     |                    |          |   |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |        | CITY OR TOWN  |                   | COUNTY                         |     | STATE              |          |   |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                      |  |   |  | STREET  |        |   |                   |                                |     |                    |          |   |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 2/1/84  |  | 19 84   |        | to 3/6  |                   | 19 84                          |     | that (I) (we) last |          |   |
| saw the deceased alive on  |  | 3/6   |  | 19 84   |        | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |                   |                                |     |                    |          |   |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |        |   |                   |                                |     |                    |          |   |
| James E. Greenwald   |  | MD  |  | 3/6/84  |        |   |                   |                                |     |                    |          |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 600 N. WOLFE ST   |        | BALTO. MD.  |                   |                                |     |                    |          |   |
| JAMES E. GREENWALD   |  | JOHNS HOPKINS HOSPITAL  |  |   |        |   |                   |                                |     |                    |          |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OF)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |        | 23d. LOCATION   |                   | CITY OR TOWN                   |     | COUNTY             |          |   |
| Burial   |  | 3-8-84  |  | Mt. View Cemetery   |        | Mountain View   |                   | Harvard                        |     | Md.                |          |   |
| 24. FUNERAL DIRECTOR   |  | NAME  |  | ADDRESS   |        | DATE REC'D. BY REGISTRAR  |                   | 25. REGISTRAR'S SIGNATURE      |     |                    |          |   |
| Harry W. Haight  |  | Sylacum, Md   |  |   |        | MAR 13 1984   |                   | [Signature]                    |     |                    |          |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of this certificate and 2 copies of page 4 and 2 copies of page 5 and 2 copies of page 6 and 2 copies of page 7 and 2 copies of page 8 and 2 copies of page 9 and 2 copies of page 10 and 2 copies of page 11 and 2 copies of page 12 and 2 copies of page 13 and 2 copies of page 14 and 2 copies of page 15 and 2 copies of page 16 and 2 copies of page 17 and 2 copies of page 18 and 2 copies of page 19 and 2 copies of page 20 and 2 copies of page 21 and 2 copies of page 22 and 2 copies of page 23 and 2 copies of page 24 and 2 copies of page 25 and 2 copies of page 26 and 2 copies of page 27 and 2 copies of page 28 and 2 copies of page 29 and 2 copies of page 30 and 2 copies of page 31 and 2 copies of page 32 and 2 copies of page 33 and 2 copies of page 34 and 2 copies of page 35 and 2 copies of page 36 and 2 copies of page 37 and 2 copies of page 38 and 2 copies of page 39 and 2 copies of page 40 and 2 copies of page 41 and 2 copies of page 42 and 2 copies of page 43 and 2 copies of page 44 and 2 copies of page 45 and 2 copies of page 46 and 2 copies of page 47 and 2 copies of page 48 and 2 copies of page 49 and 2 copies of page 50 and 2 copies of page 51 and 2 copies of page 52 and 2 copies of page 53 and 2 copies of page 54 and 2 copies of page 55 and 2 copies of page 56 and 2 copies of page 57 and 2 copies of page 58 and 2 copies of page 59 and 2 copies of page 60 and 2 copies of page 61 and 2 copies of page 62 and 2 copies of page 63 and 2 copies of page 64 and 2 copies of page 65 and 2 copies of page 66 and 2 copies of page 67 and 2 copies of page 68 and 2 copies of page 69 and 2 copies of page 70 and 2 copies of page 71 and 2 copies of page 72 and 2 copies of page 73 and 2 copies of page 74 and 2 copies of page 75 and 2 copies of page 76 and 2 copies of page 77 and 2 copies of page 78 and 2 copies of page 79 and 2 copies of page 80 and 2 copies of page 81 and 2 copies of page 82 and 2 copies of page 83 and 2 copies of page 84 and 2 copies of 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Item #5 G590 4/10/84 CW

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

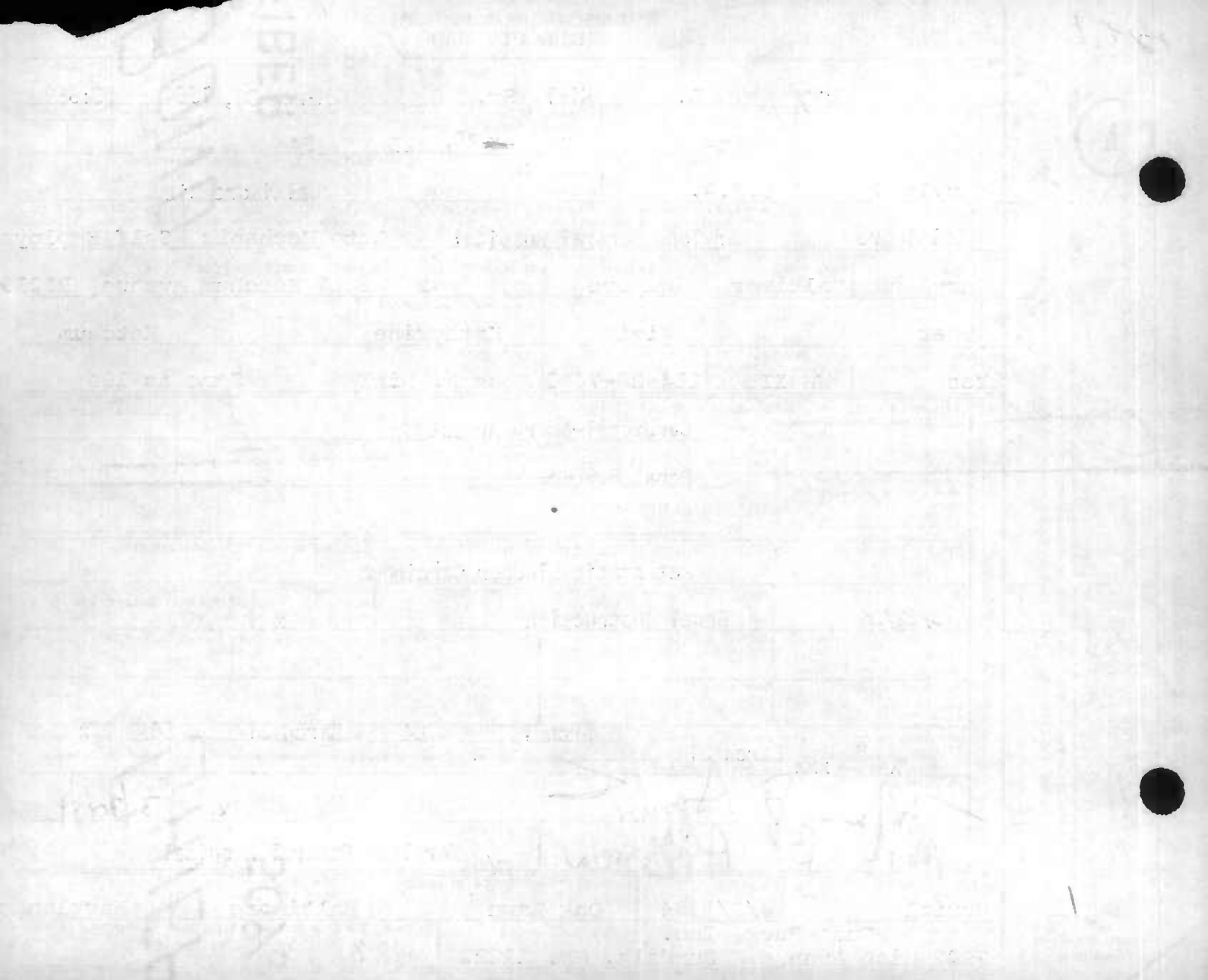
0708

REG. NO. 07089

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE  |  |
| Harry L. Kiel, Sr.  |  | Male   |  | White  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Maryland  |  | U.S.A.   |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Baltimore   |  | Maryland General Hospital  |  | Auto Mechanic  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS / ZIP CODE   |  | 13b. CITY OR TOWN  |  |
| Self Employee   |  | 2417 Ketchum Avenue 21219  |  | Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |
| Abner Kiel  |  | Katherine Ketchum  |  | Yes  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest |  |
| 214-26-7493   |  | Rose A. Kiel   |  | 5609   |  |
| 18b. SOCIAL SECURITY NO.  |  | 19. INFORMANT  |  | DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure   |  |
| 214-26-7493   |  | Rose A. Kiel   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3/22/84   |  | Bowel Obstruction  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14, 1984, to March 31, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 31, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |
| B. Applestein   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 3/30/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |
| B. Applestein   |  | c/o Maryland General Hospital  |  | Burial   |  |
| 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 4/3/1984  |  | Oak Lawn   |  | Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Duda-Ruck, Inc.   |  | APR 3 1984   |  | Davidson-Hendall   |  |
| 7922 Wise Avenue Dundalk, MD. 21222   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain the certificate at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>KATE KIESLING</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3/5/84</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11/11/00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>83</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CITY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Convalesarium</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HSWK</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>ESSEX</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM LOVELL</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNK</b>  |  | 13e. STREET ADDRESS<br><b>21221 1568 GALENA RD</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>UNK</b>  |  | 17. INFORMANT ADDRESS<br><b>GUSTAV KIESLING ABOVE</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (d) <b>CARDIAC ARREST</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC CONGESTIVE HEART FAILURE</b><br>(c) <b>A.S.C.V.D</b>        |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HOW? MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>8/31 19 82 to 3/5 19 84</b>  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>8/31</b> 19 <b>82</b> to <b>3/5</b> 19 <b>84</b> that (1) (we) last saw the deceased alive on <b>3/5</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (and) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/5/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luis E. Rivera, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>24 Scott Adam Road Cockeysville, Maryland 21030</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/8/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DAK LAWN</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>J. G. CONNELLY 300 MACE</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1984</b>  |  |   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |   |  |  |  |
|---|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marguerite Tinsley Kiley</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>22</b> YEAR <b>84</b>      |   |   | 2b. HOUR<br><b>5:30A</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>25</b> YEAR <b>45</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS                               |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                 |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Hospice Program</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b></b>   |  |   |  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1601 Spray Ct., Apt. 1</b> 21217 |  |
| 14. FATHER'S NAME<br>FIRST <b>Herman</b> MIDDLE <b></b> LAST <b>Tinsley</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Lee</b> LAST <b>Hairston</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-44-9138</b>  |  | 17. INFORMANT ADDRESS<br><b>Sophie L. Hopkins 1400 Odessa Ct., Apt. 5</b>   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1809</b> IMMEDIATE CAUSE (a) <b>Sudden death</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary metastasis secondary to</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>cervical cancer with tumor of left ureter.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Dr. David Seff</i>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. David Seff</b>  |  |   |  |   | 22e. ADDRESS<br><b>Church Hospital, 100 N. Broadway, Balto., MD 21231</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>3/27/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H Inc,</b> ADDRESS <b>1101 E North Avenue</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 28 1984</b> REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>                                   |  |   |  |  |  |

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Church Hospital Location Program

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1001 Survey Ct., Apt. 1

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Church Hospital, 100 N. Broadway  
LA 100  
777-6166

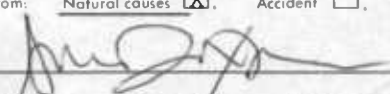
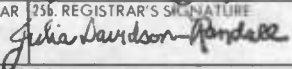
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MAR 28 1988  
FBI - Los Angeles

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |                                |   |   |   |                   | REG. NO.                                     |  |
|---|-------------------------|---|---|---|--------------------------------|---|---|---|-------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES KING</b>   |                         |   |   |   |                                |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 8 1984</b> |   | 2b. HOUR <b>M</b> |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 29, 1915</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>68</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>3 8 1984</b>                                      |   | 2d. HOUR <b>11:50</b> AM  |                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |   |   |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager of Apt. Complex</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                   |  |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>----</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3806 Pascal Ave., 21226</b>                               |                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Edward Lease</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Riemersnyder</b>  |                                |   |   |   |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>219-30-6543</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Joseph R. King Coppens Cove, Tx. 76522</b><br><b>502 Creek St.,</b>  |                                |   |   |   |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |   |   |                                |   |   |   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |                                |   |   |   |                   |  |  |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |   |   |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |   |   |                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |                                |   |   |   |                   |  |  |
| ACTUAL SIGNATURE<br>   |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |   |   |                                | DATE SIGNED <b>3-8-84</b>   |   |   |                   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                         | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |   |   |                                |   |   |   |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |                         | 23b. DATE<br><b>3/12/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |                                |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, A. A. Co., Md.</b>      |                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Homes</b>  |                         |   |   | ADDRESS<br><b>Balto., Md., 21225</b><br><b>237 E. Patapsco Ave.,</b>  |                                |   |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>                                    |                   |  |  |
|   |                         |   |   | 25b. REGISTRAR'S SIGNATURE<br>   |                                |   |   |   |                   |  |  |

SECRET  
U.S. GOVERNMENT PRINTING OFFICE: 1964

1. The purpose of this study is to determine the effect of the proposed changes on the overall system. The study will be conducted in three phases: (a) a review of the current system, (b) a comparison of the proposed changes with the current system, and (c) a determination of the effect of the proposed changes on the overall system.

92819



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07093

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mamie KING</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 8, 1984</b> |   |  | 2b. HOUR<br><b>2:40A</b> M  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 22 1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>462 TUBMAN COURT 21201</b>  |  |   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM BRADFORD</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLA GREEN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>RUTH GRAVES 451 WALTON COURT 21201</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: <b>Myocardial Infarction</b><br><b>4100</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 29</b> , 19 <b>84</b> , to <b>March 8</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 8</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did <input checked="" type="checkbox"/> view the body after death. |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Harry E. Nervino, M.D.</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/8/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harry E. Nervino, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-12-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS 1721 N. MONROE ST.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>   |  |   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Judith Davidson-Randall</b>  |  |   |  |



FILED

COPIES

March 2, 1984

Baltimore City

General Hospital

Baltimore

Myocardial Infarction

Coronary Artery Disease

X

February 20

March 2

March 2

Harry E. Levine, M.D.

c/o General Hospital

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PM-3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 FOR BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |  |  |   |  | REG. NO.   |  |   |  |
|--|--|------------------|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>PAUL A. KING   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br>3-22-84 19 |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 18, 1965 18  |  | 6. AGE (IN YEARS) MONTHS DAYS<br>18                          |  | IF UNDER 24 HRS. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>3-22-84 19   |  | 2d. HOUR<br>2:10P<br>M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital STU |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.  |  |                  |  | 13b. COUNTY<br>Baltimore  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>141 S. Morley Street 21229                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas C. Plummer, Jr.  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Myrtle A. King |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No   |  |                  |  |   |  | 16b. SOCIAL SECURITY NO.                                     |  |   |  |  |  | 17. INFORMANT ADDRESS<br>Myrtle A. King (Mother) same as #13                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shotgun wound of left chest<br>9651<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR MIN. DAY MONTH YEAR<br>10:41 AM 3-22-84 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  |  |  | 21f. LOCATION (CITY OR TOWN, COUNTY, STATE)<br>4604 Parkton St. (rear) Balto., Maryland   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |  |                  |  | TITLE (SPECIFY)<br>Assistant  |  |  |  | MEDICAL EXAMINER<br>111 Penn Street   |  |  |  | DATE SIGNED<br>3-23-84  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>3-28-84  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Daisy Cemetery  |  |  |  | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE)<br>Daisy, Howard, Md.                   |  |
| 24. FUNERAL DIRECTOR NAME<br>George R. Snowden   |  |                  |  | ADDRESS<br>246 N. Washington St.<br>Rockville, Md. 20850  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 30 1984  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                |  |

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

1

DATE

REBIB NOT TO

NYA

10/15/54

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| FOR<br>STATE<br>REGISTRAR  |  |                      |  |  |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH           |  |  |  |  |  |  |  |  |  | REG. NO.                 |  |
|--|--|----------------------|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ronald V. King</b>  |  |                      |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3/20/84</b> 19 |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>4:52</b> P M |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 2 1966</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>17</b> YRS.                   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD <b>3/20/84</b> 19   |  | 2d. HOUR <b>4:52</b> P M   |  |  |  |  |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |  |  |  |  |  |  |                          |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1013 N. Charles Street</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>  |  |  |  |  |  |  |  |                          |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      |  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS <b>1013 N. CHARLES ST. 21201</b> |  |  |  |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>ROBERT KING</b>  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>CAROLYN SPECHT</b> |  |   |  |  |  |  |  |  |  |  |  |  |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |                      |  |  |  | 16b. SOCIAL SECURITY NO. <b>—</b>                                   |  |   |  |  |  | 17. INFORMANT ADDRESS <b>ROBERT KING (SAME AS 13)</b>  |  |  |  |  |  |  |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9554</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |                      |  |  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |  |  |  |                          |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>? P.M. 3/19/84</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted wound</b>   |  |  |  |  |  |  |  |  |  |  |  |                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>bedroom</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>1013 N. Charles Street, Balto. City, Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |                          |  |
| 22a. I certify that I took charge of the remains described above and on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>HEAD ONLY</b><br><b>HEAD ONLY</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                          |  |                      |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |                          |  |
| ACTUAL SIGNATURE <b>Gregory R. Kauffman</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  |   |  |   |  | DATE SIGNED <b>3/21/84</b>   |  |  |  |  |  |  |  |  |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>MARCH 23, 1983</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CROWNVILLE VETERANS CEM.</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>CROWNVILLE ANNE ARUNDEL MD.</b>                |  |  |  |  |  |  |  |                          |  |
| 24. FUNERAL DIRECTOR NAME <b>ROBERT S. BARRANCO</b>  |  |                      |  | ADDRESS <b>501 RITCHIE HWY SEVERNA PARK, MD.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1984</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>                                      |  |  |  |  |  |  |  |                          |  |

STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

SECTION 17

WATER RIGHTS

WATER RIGHT NO. 1

WATER RIGHT NO. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | WILLIAM B. KINZEL JR.  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>William B. Kinzel Jr.   |  |  |  |   | 2a. DATE OF DEATH<br>3/11/84   |   |  | 2b. HOUR<br>9:15 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>6 26 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Shipping Clerk |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Can Co.   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. CITY OR TOWN<br>Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13d. STREET ADDRESS<br>207 Ingleside Avenue 21228                    |  |  |
| 14. FATHER'S NAME<br>William B. Kinzel Sr.  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Pauline Raber  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW 2   |  | 17. INFORMANT<br>Jean Kinzel  |  | ADDRESS<br>Same as # 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br><u>4280</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Severe COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHF</u> |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>many years</u><br><u>many years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal Failure and Anuria For 6 days.</u>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>84</u> , to <u>3/11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>R. Girgis</u>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Raafat Y. Girgis</u>  |  |  |  |   | 22e. ADDRESS<br><u>St. Agnes Hospital - Baltimore MD</u>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |  |  | 23b. DATE<br><u>3/14/84</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westview Crematory</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonsville Md.</u> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Witzke Funeral Home</u>  |  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br><u>3/14/84</u>   |   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Johanna Davidson-Landall</u>   |  |  |  |   |  |   |  |  |  |



11/11/54  
J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D. C.  
20535

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. One copy of the same is being furnished to the Department of State for its information.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALICE ARNETT KIRBY</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>6</b> YEAR <b>84</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>15</b> YEAR <b>05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>717 Druid Park Lake Dr.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Handy</b> LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Emma</b> MIDDLE <b>Gould</b> LAST                    |  | 13e. STREET ADDRESS<br><b>717 Druid Park Lake Dr.</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>21230 Alice Ali 2616 Hollins Ferry Rd.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiovascular disease</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>—</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b><br><b>20 years</b> |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>—</b>  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>October</b> , 19 <b>83</b> , to <b>October</b> , 19 <b>83</b> , tho (1) (we) last saw the deceased alive on <b>October</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Maum J. McGuire</b>   |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/18/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maum J. McGuire</b>  |  |   |  | 22e. ADDRESS<br><b>1620 McElenny St</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/10/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bailey Funeral Home 1348 N. Calhoun</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 07098  |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John Armstrong KIRBY</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 12, 1984</b>  |  | 2b. HOUR<br><b>6:00 A M</b>   |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 5, 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>149 W. Lafayette Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Post Office</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govern't</b>   |   |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward John Kirby</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Adelaide Hughlett</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI</b>   |  | 17. INFORMANT<br><b>Nephew:</b> ADDRESS<br><b>Kenneth C. Martin, Washington, D. C. 20016</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial pneumonia.</b><br>4850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 26th</b> 19 <b>83</b> , to <b>March 12</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 2</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>George Taler M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/12/84</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE TALER, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>600 LIGHT ST. BALT. MD. 21230</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/14/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto. County</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>STEWART &amp; MOWEN CO., 108 W. North Ave. 21201</b>   |  |   |  | 25. DATE RECD. BY REGISTRAR<br><b>MAR 14 1984</b>   |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 and file them in the file box provided in the funeral home. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and an autopsy may be required.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE E. KIRCHER</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 4, 1984</b>                             |  |   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>1 22 10</b>                                    |  | 2b. HOUR P <b>11 30 M</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>   |  | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>  |  | 12b. COUNTY <b>Howard</b>  |  | 12c. CITY OR TOWN <b>Elkridge</b>   |  | 12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13a. STREET ADDRESS <b>21227 7236 Montgomery Road A-3</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Suzanne</b>   |  | 13c. STREET ADDRESS <b>21227</b>  |  | 13d. STREET ADDRESS <b>7236 Montgomery Road A-3</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Lafferty</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Suzanne</b>  |  | 16. SOCIAL SECURITY NO. <b>n/a</b>  |  | 17. INFORMANT ADDRESS <b>Raymond E. Kircher 7948 E. Park Dr. 21061</b>  |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)  |  | 20. SOCIAL SECURITY NO. <b>n/a</b>  |  | 21. INFORMANT ADDRESS <b>Raymond E. Kircher 7948 E. Park Dr. 21061</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Brain Anoxia</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Complete Atrioventricular Block &amp; Electromechanical Dissoc.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Inferior Myocardial Infarction.</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Perforated Acute Duodenal Ulcer treated by coledymy, previous antecubital ME</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>3/4</b> 19 <b>84</b> to <b>3/4</b> 19 <b>84</b> , that (he) (we) last saw the deceased alive on <b>3/4/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) (did not) view the body after death.             |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Andrew Gordon</b>  |  | 22c. DEGREE <b>MD</b>  |  | 22d. DATE SIGNED <b>3/5/84</b>  |  | 22e. ADDRESS <b>St. Agnes Hospital</b>  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW GORDON</b>   |  | 22g. ADDRESS <b>St. Agnes Hospital</b>   |  | 22h. ADDRESS <b>St. Agnes Hospital</b>  |  | 22i. ADDRESS <b>St. Agnes Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3/8/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>  |  | 24b. ADDRESS <b>4107 Wilkens Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 8 1984</b>                                   |  | 25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HENRY</b>   |  | FIRST MIDDLE LAST <b>KNAPP</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3.5.84</b>   |  | 2b. HOUR <b>7:10A</b>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>CAUS.</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>07/13 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY OF BALTIMORE MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICIAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>TOWSON</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE <b>APT. 202 46 ACORN CIRCLE</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>C. HERBERT KNAPP</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE C. KLEIN</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WW2</b>                                       |  |   |  |
| 17. SOCIAL SECURITY NO. <b>216.12.0406</b>   |  | 18. INFORMANT ADDRESS <b>HERBERT KNAPP 4714 KNAPP COURT 21043</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NEURASTHATIC PROSTATIC CARCINOMA</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (if (this hospital) attended the deceased from <b>11/23</b> 19 <b>84</b> to <b>3/5</b> 19 <b>84</b> , that (we) last saw the deceased alive on <b>3/5</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  | DEGREE <b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>3/5-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VERMONT</b>   |  | 22e. ADDRESS <b>8124</b>   |  | 22f. ADDRESS <b>200 HOPEWOOD TERRACE BALTO 21201</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>MAR. 8, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 8 1984</b>  |  |   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "1" above any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |                             |  |  |
|---|--|---|--|---|--|---|-----------------------------|--|--|
| 1. FOR STATE REGISTRAR<br>BERNADETTE V. KNIGHT  |  |   |  |   | REG. NO.   |   |                             |  |  |
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>BERNADETTE V. KNIGHT   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 28 1984   |   |                             | 2b. HOUR<br>11:25A   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 21 1916   |  | 6. AGE<br>IN YEARS LAST BIRTHDAY<br>67 YRS  |                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7. BIRTH PLACE<br>(COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                             |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT AGNES HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             | 13e. STREET ADDRESS / ZIP CODE<br>8 Heights Avenue 21228   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Durnin   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mattie Sullivan   |   |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>220-74-4967   |  | 17. INFORMANT<br>10110 DRESS Frederick Road 21043<br>Albert W. Buchwald Jr. - Ellicott City, Md.  |  |   |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |  |   |                             |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>84</u> , to <u>3-28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |                             |  |  |
| 22b. SIGNATURE<br><u>Qui Dien Huynh</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>3-29-84 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>QUI DIEN HUYNH   |  |   |  |   | 22e. ADDRESS<br>STAGNES HOSP. CATON AV. BALTO - MD 21229   |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/31/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Md.                                |                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lester M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 30 1984  |                             | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendell</u>  |  |

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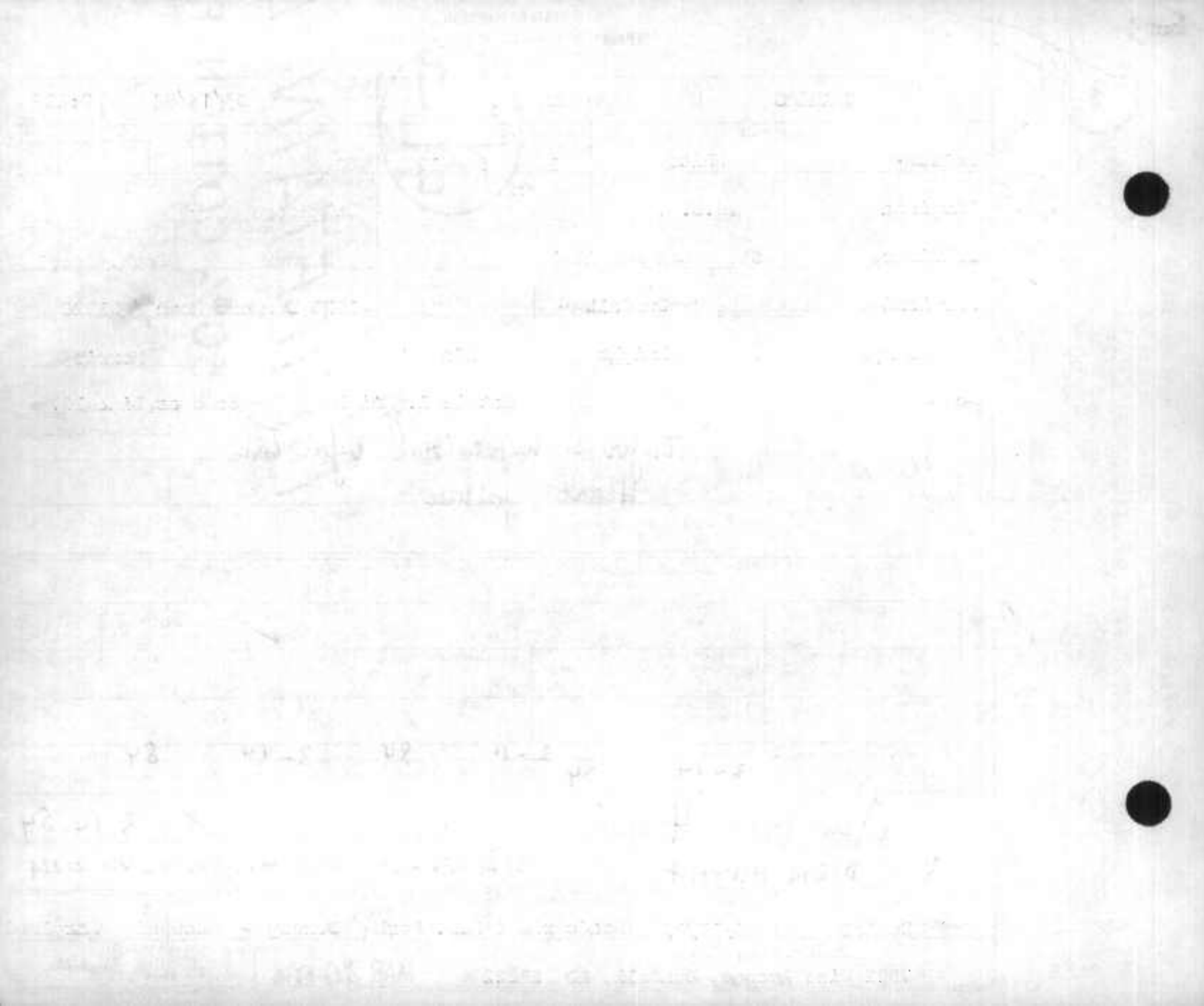
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called and a medical certificate filed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES M KNIGHT, SR.</b>   |  |  |  |   | 2a. DATE OF DEATH: MONTH <b>03</b> DAY <b>14</b> YEAR <b>84</b>  |  |  | 2b. HOUR <b>8:28P</b> M                                 |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>5</b> YEAR <b>1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Burner</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1826 Dunmere Road 21222</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>A.</b> LAST <b>Knight</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ida</b> MIDDLE <b></b> LAST <b>Morris</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-03-0538</b>  |  | 17. INFORMANT<br><b>Hattie I. Knight</b>  |  |  | ADDRESS<br><b>Same as Line 13.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Inferior myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-11</b> , 19 <b>84</b> , to <b>3-14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3-14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Qui Dien Huynh</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-14-84</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>QUI DIEN HUYNH</b>   |  |  |  |   | 22e. ADDRESS<br><b>ST AGNES HOSP., CATON AVE., BALTO - MD 21224</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/17/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Dorsey</b> COUNTY <b>Howard</b> STATE <b>Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a copy of the law, see the instructions to the attending physician on the back of this certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE NORRIS KNIGHT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 7 84</b> |  | 2b. HOUR<br><b>6:30 pm</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 7 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                | 13d. STREET ADDRESS / ZIP CODE<br><b>1620 N. Bond Street 21213</b>                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Norris Knight</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Violet Crafton</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218 05 5056</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Hazel B. Knight 1620 N. Bond Street</b>               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>2780</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MORBID OBESITY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>PYREXIA</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 9, 19 84</b> , to <b>MARCH 7, 19 84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 7, 19 84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Ralph J. Panos MD</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  | 22c. DATE SIGNED<br><b>3/8/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ralph J Panos MD</b>  |  | 22e. ADDRESS<br><b>LRVAH</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/13/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA Owings Mills, Md.</b>    |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson Handell</b>                           |   |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARTIN F. KNOTT</b>   |  |   |  | 2b. HOUR<br><b>2:56</b> M  |  |   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 3 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>76</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. V.P.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  |   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Balto.</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>6001 Huntridge Road 21227</b>  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry A Knott</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha M Doyle</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |   |
|  |  | 16b. SOCIAL SECURITY NO.<br><b>215 07 0494A</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Elizabeth V. Knott Same</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Excessive heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 weeks</b><br><b>13 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Thrombotic vascular disease; possible sepsis; chronic acute renal failure; Diabetes mellitus</b>   |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/27/84</b> , 19 <b>84</b> , to <b>3/23</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Thomas Adams Corson M.D.</b>  |  |   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>MARCH 23, 1984</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS ADAMS CORSON, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>90 JOHNS HOPKINS HOSPITAL, N. WOLFEST, BALTIMORE, MD 21205</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/26/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto Md</b>   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 27 1984 Julia Davidson-Randall</b>  |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |  |   |  |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST Anna MIDDLE Veronica LAST Knowles<br><i>Anna V. Knowles</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/25/84                         |   |  | 2b. HOUR<br>7:40 AM  |   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/13/20   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Beautician   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Shop  |   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Dundalk                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST Frank MIDDLE LAST Pac  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Anna MIDDLE LAST Lewandoski          |   |  | 16. STREET ADDRESS / ZIP CODE<br>3106 Dunglew Road 21222   |   |  |   |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 18. SOCIAL SECURITY NO.<br>214-16-6412                                 |   | 19. INFORMANT<br>Cathy R. Knowles                        |  |   |  | 20. ADDRESS<br>3106 Dunglew Road<br>Balto. MD 21222 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Collapse</i><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Squamous cell lung Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year 2 mos.  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>✓   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>✓                  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/25, 19 84, to 3/25, 19 84, that (1) (we) lost saw the deceased alive on 3/25, 19 84, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Ira Shapiro</i>  |  |  | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>3/25/84  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ira Shapiro MD   |  |  | 22e. ADDRESS<br>Baltimore City Hospital                                |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>3/28/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc. ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1984   |   |  |   |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>  |   |  |   |  |

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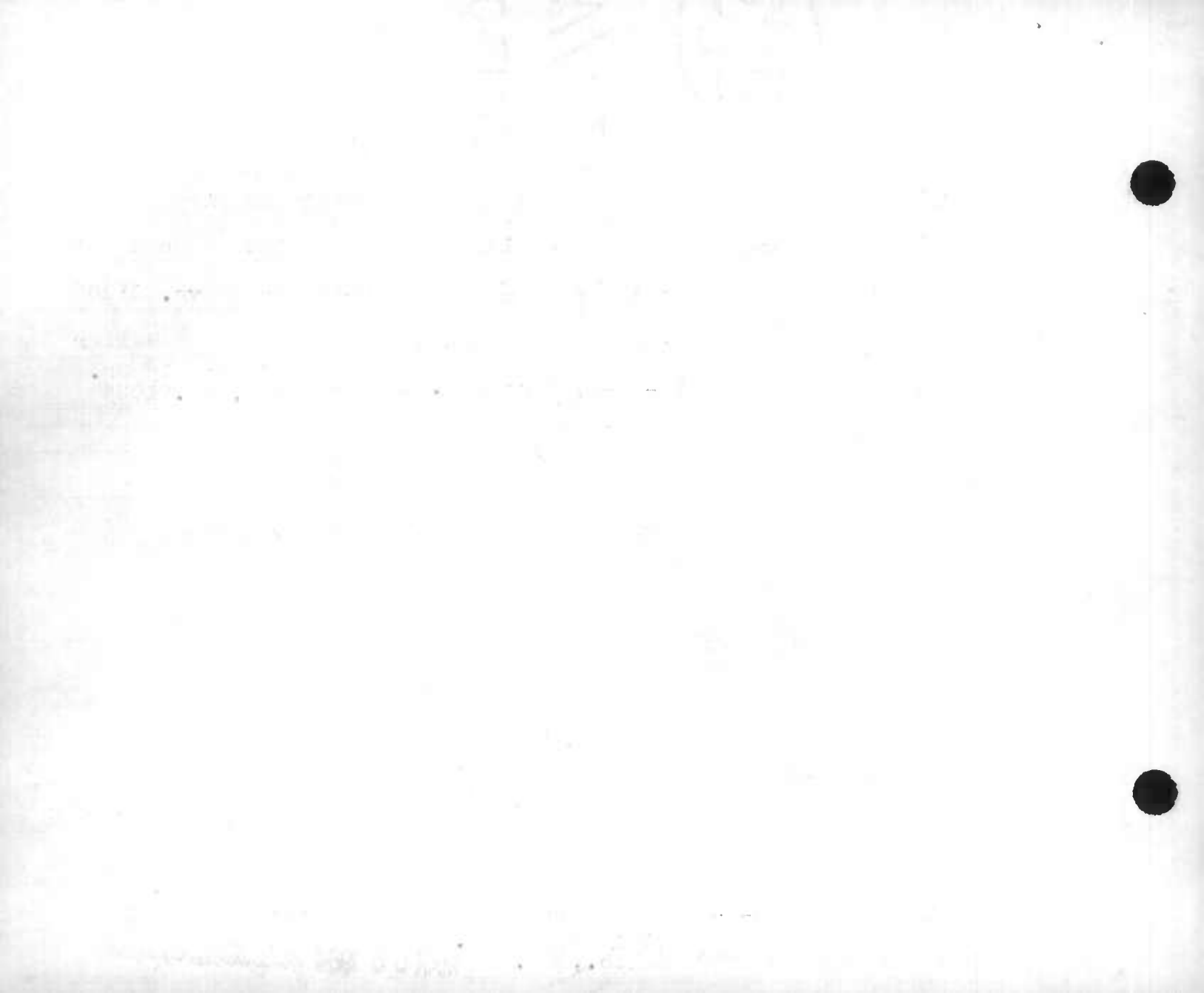
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EMMA Anna KORYTO  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-4-84   |  |  | 2b. HOUR<br>12:15 AM  |  |
| 3. SEX<br>F  |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>02 13 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                 |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 9b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13e. STREET ADDRESS / ZIP CODE<br>3905 Walnut Ave. 21206                   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Long  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rose Haller  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>216-28-4784  |  | 17 INFORMANT ADDRESS<br>John R. Koryto 2405 Beverly Dr. Joppa, Md. 21085 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GI Bleeding + Respiratory failure</u><br>2051<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>EOSINOPHILIC LEUKEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>PAPILLARY CA OF THYROID (MULTIPLE METS)</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>02/28/84</u> , 19 <u>84</u> , to <u>3/4/84</u> , 19 <u>84</u> , that (I) (we) lost the deceased alive on <u>3/3/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.  |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE <u>V. Prabaker</u>  |  |   |   |   | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>3/4/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V. PRABAKER, MD   |  |   |   |   | 22e. ADDRESS<br>GOOD SAMARITAN HOSPITAL, BLVD, BALTIMORE   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3-7-84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland            |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Lassahn Funeral Home  |  |   |   |   | 7401 Belair Rd. Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 08 1984                             |   |  |
|  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGUERITE E. Kraft</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> - DAY <b>4</b> - YEAR <b>84</b> |   |  | 2b. HOUR<br><b>5<sup>46</sup></b> P. M.   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>March</b> - DAY <b>25</b> - YEAR <b>1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital, Balto. Md.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>---</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>---</b> LAST <b>Neisser</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pauline</b> MIDDLE <b>---</b> LAST <b>Unknown</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-44-3347</b>  |  | 17. INFORMANT ADDRESS<br><b>21230</b><br><b>Mr. Willard M. Kraft, 210 E. Randall St. Balto. Md.</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STROKE</b><br><b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>METASTATIC CANCER, UNKNOWN PRIMARY</b><br>(c) <b>UNKNOWN</b>                  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 HOURS</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> 19 <b>84</b> to <b>3/7</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/7</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Walter J. Alt, MD</b>  |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/7/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER J. ALT, MD</b>   |  |  |   | 22e. ADDRESS<br><b>301 MARYDELL RD<br/>BALTIMORE, MD 21229</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>March 7, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co. Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b> ADDRESS <b>21230</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1984</b> REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>  |  |   |  |





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20X7-COL-03M-116



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07108

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**ANTHONY B. KRASKI**

2a. DATE OF DEATH MONTH DAY YEAR  
**March 24, 1984**

2b. HOUR  
**4: P.M.**

3. SEX  
**M**

4. RACE  
**WHITE**

5. DATE OF BIRTH MONTH DAY YEAR  
**12-18-1926**

6. AGE (IN YEARS LAST BIRTHDAY)  
**57** YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**MD.**

7b. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**BALTO. CITY** MD.

10. CITY OR TOWN OF DEATH  
**BALTO.**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**SIANI HOSP.**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**BALTO. CITY**

12b. KIND OF BUSINESS OR INDUSTRY  
**DEPT. OF**

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
**MD.**

13b. COUNTY  
**BALTO.**

13c. CITY OR TOWN  
**BALTO.**

13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e. STREET ADDRESS  
**3104 FOSTER AVE.**

14. FATHER'S NAME FIRST MIDDLE LAST  
**JOHN KRASKI**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**ELIZABETH KRYGER**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**YES**

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR CATEGORIES)  
**220-18-8959**

17. INFORMANT ADDRESS  
**MR. JOSEPH KRASKI 3104 FOSTER AVE 21224**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Acute Myocardial Infarction**  
**4100**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?  
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **3/24**, 19 **78**, to **3/24**, 19 **84**, that (I) (we) last saw the deceased alive on **3/24**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
**James J. Elmer MD**

22c. DATE SIGNED  
**3/27/84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**BYRON B. ELMA MD**

22e. ADDRESS  
**3023 Eastern Ave Balto MD 21224**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**BURIAL**

23b. DATE  
**3-28-84**

23c. NAME OF CEMETERY OR CREMATORY  
**SAC. HEART OF JESUS**

23d. LOCATION CITY OR TOWN COUNTY  
**BALTO. MD.**

24. FUNERAL DIRECTOR NAME  
**THOMAS J. SKARDA F.H. 2829 HUDSON ST.**

25a. DATE REC'D. BY REGISTRAR  
**MAR 27 1984**

25b. REGISTRAR'S SIGNATURE  
**Julia Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate must be completed.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07109

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |   |   |  |  |
|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KARL (NONE) KRATZMEIER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-26-84</b>                 |   |   | 2b. HOUR<br><b>8<sup>10</sup> P.M.</b>  |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-28-01</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSP.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Route Salesman-Bakery</b>                |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4022 WALRAD ST. 21229</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RUDOLPH KRATZMEIER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH ? ?</b>   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-01-7860</b>   |  | 17. INFORMANT <b>4022 Walrad St. Balto., Md. 21229</b><br><b>MEDICAL RECORDS Clara E. Kratzmeier</b>  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF THE LUNG</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 MO.</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>COPD - ASCVD - DIABETES MELLITUS</b>  |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10</b> 19 <b>80</b> to <b>PRESENT</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3-26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Oscar E. Ferdinand M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |   | 22c. DATE SIGNED<br><b>3-27-84</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSCAR E. FERNANDINI M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>5550 BALTO. NATL. PIKE BALTO. MD. 21228</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(RECEIVED) <b>Cremation</b>  |  |   | 23b. DATE<br><b>Mar. 30, 1984</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk. Cem.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. TRUMAN SCHWAB</b> ADDRESS<br><b>3512 FREDERICK AVE. #31229</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1984</b> 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |   |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>[TYPE OR PRINT] <b>Gilbert L. Kreusinger</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-10-84</b>                  |   |  | 2b. HOUR<br><b>2:15 PM</b>  |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 24 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>[STATE OR FOREIGN COUNTRY]<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>J.L. Deaton 611 S. Charles Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Glazer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City Sch</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>--</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stephen Kreusinger</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Yeakle</b> |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3724 Hickory Avenue 21211</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216 24 6276</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Gerard Kreusinger 4405 Buchanan Ave. 21211</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of rectum &amp; metastases</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 5, 1984</b> to <b>March 10, 1984</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 10, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Julian W. Reed M.D.</b>   |  |   | DEGREE   |   |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/12/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIAN W. REED M.D.</b>  |  |   | 22e. ADDRESS<br><b>611 S. CHAS. ST. BALTO. MD 21230</b>                |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/14/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home, 3631 Falls Road 21211</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>John B. ...</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1841

1841





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

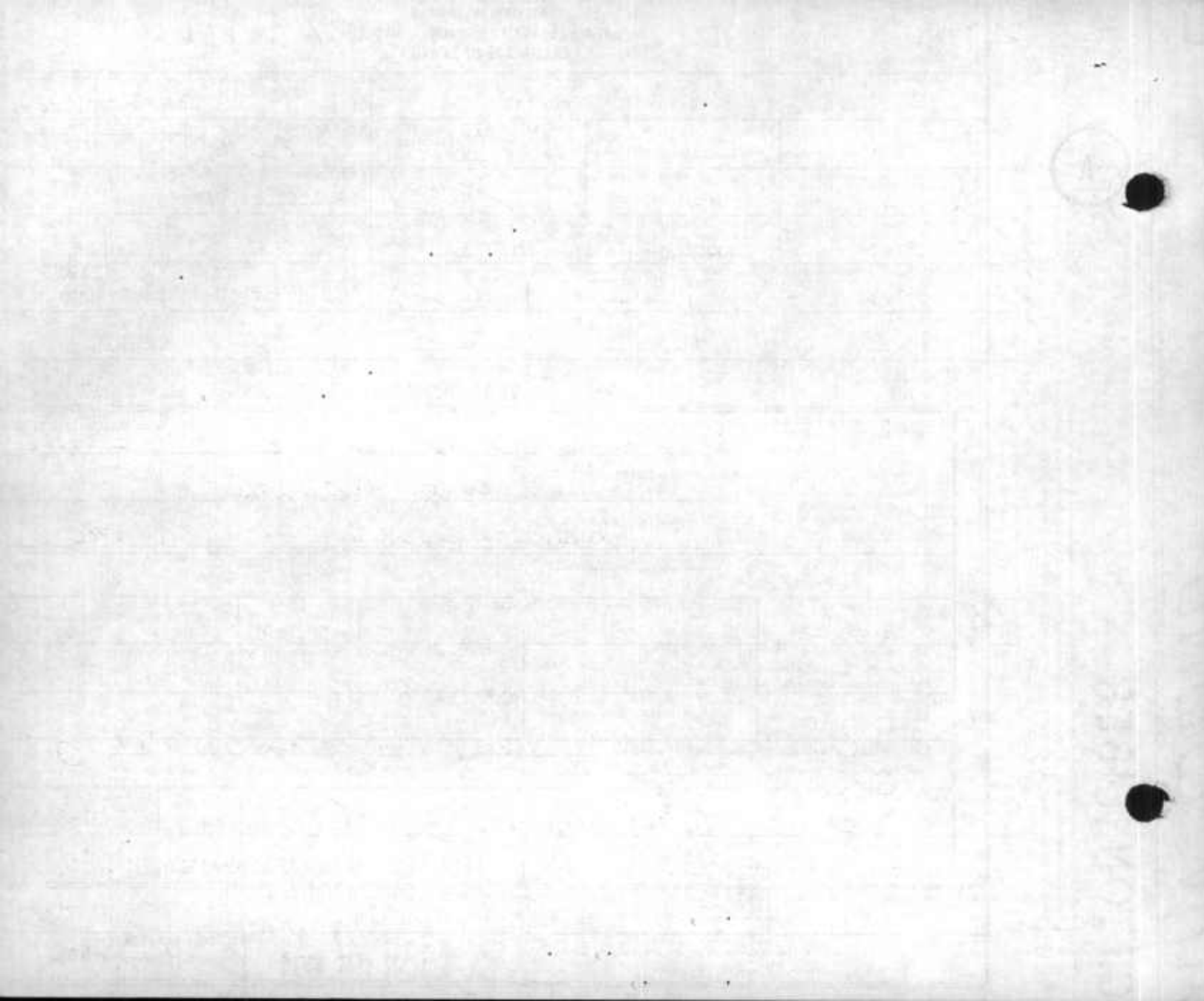
|  |  |   |   |  |  |
|--|--|---|---|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |   | 7 1 1 1   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | 2a. DATE OF DEATH                                       |  |  |
| Lea S. Krostar   |  |   | MONTH DAY YEAR<br>3 21 84                               |  |  |
| 3. SEX   |  |   | 2b. HOUR  |  |  |
| Female   |  |   | 1:20 PM   |  |  |
| 4. RACE  |  |   | 5. DATE OF BIRTH  |  |  |
| Caucasian  |  |   | MONTH DAY YEAR<br>6 16 1901                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                         |  |  |
| RUSSIA   |  |   | 82 YRS.   |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                    |  |  |
| USA  |  |   | Baltimore City  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |
| Baltimore  |  |   | APT. C<br>XXXXX 6516 PARK HTS. AVE.                     |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |
| HOUSEWIFE  |  |   | AT HOME   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13b. STREET ADDRESS                                     |  |  |
| 13a. STATE   |  |   | APT. C #21215<br>6516 Park Heights Avenue               |  |  |
| 13b. COUNTY  |  |   | 13c. CITY OR TOWN                                       |  |  |
| Maryland   |  |   | Baltimore   |  |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME                                |  |  |
| FIRST MIDDLE LAST<br>JACOB SCHWARTZ  |  |   | FIRST MIDDLE LAST<br>SOSSIA ORNSTEIN                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO                                 |  |  |
| NO   |  |   | 217-14-6229   |  |  |
| 17. INFORMANT  |  |   | 17. INFORMANT   |  |  |
| MRS. DIANE BLUMBERG  |  |   | 7105 BROXBURN DR. BETHESDA, MD 20817                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |   |  |  |
| IMMEDIATE CAUSE (a) <u>acute renal failure</u>   |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |  |  |
| (b) <u>urinary tract obstruction</u>   |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |  |  |
| (c) <u>rectal carcinoma</u>  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| none   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   | 20a. AUTOPSY?  |  |
| none   |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (he, she, it) (this hospital) attended the deceased from <u>Feb</u> 19 <u>84</u> , to <u>Mar 21</u> 19 <u>84</u> , that (he, she, it) last saw the deceased on <u>Mar 12</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.) |  |   |   |  |  |
| 22b. SIGNATURE   |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| Bruce Rosenberg  |  | ATTENDING PHYSICIAN   |   | 3-21-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |  |
| Bruce Rosenberg, M.D.  |  | 1134 York Road Lutherville, Md. 21093                               |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL   |  | MAR. 22, 1984   |   | OHR KNESSETH ISRAEL  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  |  |
| SOL LEVINSON & BROS., INC.   |  | ANSIE STARD   |   | MAR 23 1984  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |   | J. Davidson  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  | REG. NO.  |  |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert James Kruszyński</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 29, 1984</b>                       |  | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 26 79</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>5</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Eastwood</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 4. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Francis Kruszyński</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Angela Eyster</b>         |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>5829</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>James F. Kruszyński 7258 Conley St 21224</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5829</b> IMMEDIATE CAUSE (a) <b>Caroline Arrost</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Saul Roskes, M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/2/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAUL D. ROSKES, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>10807 FALLS Rd., LUTHERVILLE, Md. 21784</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-2-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastwood, Balto., Co., Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Zeiler &amp; Son Inc.</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 2 - 1984 Julia Davidson-Randall</b>  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |  |  |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CONSTANCE E. KUCIARA</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>12</b> YEAR <b>84</b>   |   |  | 2b. HOUR<br>M   |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>29</b> YEAR <b>29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>315 S. WOLFE STREET</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>           |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>315 S. WOLFE STREET</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>VINCENT</b> MIDDLE <b>—</b> LAST <b>ZAGROBA</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE <b>—</b> LAST <b>FIGINSKI</b>  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>—</b> (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>930-24-3811</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOSEPH C. KUCIARA 315 S. WOLFE ST.</b>                           |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory Arrest</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Tracheal Stenosis</b><br>(c) <b>Arteriosclerotic and Vascular Brain</b> |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>8 months</b><br><b>years</b>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-6</b> 19 <b>81</b> to <b>3-12</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-12</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.     |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Rolando V. Goco, M.D.</b>  |  |   |  |   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3-13-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rolando V. Goco, M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>707 E. Fort Ave. Balt. Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>3/16/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy ROSARY Cem. BALTO.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L KACZOROWSKI</b>  |  |   |  |   |  | ADDRESS<br><b>3526 Fleet St.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1984</b>  |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's resources and its potential for development. The author has done a great deal of research and has gathered a wealth of material which is presented in a clear and concise manner. The report is well organized and easy to read. It is a valuable contribution to the knowledge of the country and its resources.

2. The second part of the report deals with the specific details of the country's resources. It is a very detailed and thorough study of the country's resources and its potential for development. The author has done a great deal of research and has gathered a wealth of material which is presented in a clear and concise manner. The report is well organized and easy to read. It is a valuable contribution to the knowledge of the country and its resources.

3. The third part of the report deals with the specific details of the country's resources. It is a very detailed and thorough study of the country's resources and its potential for development. The author has done a great deal of research and has gathered a wealth of material which is presented in a clear and concise manner. The report is well organized and easy to read. It is a valuable contribution to the knowledge of the country and its resources.

4. The fourth part of the report deals with the specific details of the country's resources. It is a very detailed and thorough study of the country's resources and its potential for development. The author has done a great deal of research and has gathered a wealth of material which is presented in a clear and concise manner. The report is well organized and easy to read. It is a valuable contribution to the knowledge of the country and its resources.

5. The fifth part of the report deals with the specific details of the country's resources. It is a very detailed and thorough study of the country's resources and its potential for development. The author has done a great deal of research and has gathered a wealth of material which is presented in a clear and concise manner. The report is well organized and easy to read. It is a valuable contribution to the knowledge of the country and its resources.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay in the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | REG. NO.  |  |  |  |
|---|--|---|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Michael KUCZAK  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 15 1984                         |  |  |  |
| 3. SEX<br>MALE  |  |   |  |   | 2b. HOUR<br>M   |  |  |  |
| 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>FEB. 18 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>AIRWAY CIRCLE |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF EMPLOYED  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>TOWSON   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE KUTCHOCK   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CATHERINE MISKA  |  | 13e. STREET ADDRESS<br>11 AIRWAY CIRCLE 21204   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>216 03 0242   |  | 17. INFORMANT ADDRESS<br>DOROTHY YOUNGER 1650 MARYBY RD   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Diabetes mellitus   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/12, 1982, to 3/15, 1984, that (I) (we) last saw the deceased alive on 2/18, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not, see the body after death.)   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Joseph J. Daniels MD  |  |   |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/6/84                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>3/19/1984  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CAR LAWN CEMETERY   |   | 23d. LOCATION<br>BALTIMORE CO MD   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Raymond H. Kaczorowski  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>MAR 19 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <b>LENA D. KUEHN</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3-8-84</b> 2b. HOUR <b>8:10 P.M.</b>   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LENA D. KUEHN</b>   |  | 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1-4-1898</b>  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b>                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Kuehn</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rebecca Helms</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5006 Edmondson Avenue 21229</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-7640</b>   |  | 17. INFORMANT ADDRESS<br><b>Charles W. Reinhardt Same as # 13</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149 Cardio-pulmonary arrest</b><br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASVD</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Problems with lungs</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>3/8 1984</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>84 3/8 1984</b>   |  | 21g. LOCATION CITY OR TOWN COUNTY STATE<br><b>84</b>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/8 1984</b> to <b>3/8 1984</b> , that (I) (we) lost saw the deceased alive on <b>3/8 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Elmo M. Gaydos</b>  |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elmo M. Gaydos</b>   |  | 22e. ADDRESS<br><b>Bon Secours Hospital, Baltimore, Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/12/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |
| 1630 Edmondson Avenue, Catonsville, Md. 21228  |  |  |  |  |  |   |  |

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |   |  |  |
|---|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>STEPHANIE KUREK</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 24, 1984</b>                  |   |  | 2b. HOUR<br><b>7:45 AM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-27-1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 yrs.</b>  |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>420 Westgate Road</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sewing Co.</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leopold Twardoski</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Porkosz</b>          |   |  | 16. STREET ADDRESS / ZIP CODE<br><b>420 Westgate Road 21229</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-05-7012</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Anthony Kurek Jr. 420 Westgate Road 21229</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>1991 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic adenocarcinoma</b> |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>2 days</b><br><b>1 year</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 19 83</b> to <b>March 19 84</b> , that (I) (we) lost saw the deceased alive on <b>3/23</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Robert Puharoy MD</b>  |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/24/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3-27-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary</b>                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>Schamunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto., Md. 21213</b>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1984</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lila Davidson-Randall</b>   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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MAR 27 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>WANDA KUROWSKI   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 15, 1984  |  | 2b. HOUR<br>9:35pm   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 1, 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Factory Worker  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>607 S. Wolfe St. 21231  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanislaus Kurat  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Franczeska Kosmalski  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IF OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>218-03-3142   |  | 17. INFORMANT ADDRESS<br>Milton Kurowski 607 S. Wolfe Street   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>1541<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CANCER OF RECTUM</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from FEB. 17, 1984, to MAR 15, 1984, that (1) (we) last saw the deceased alive on MAR 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>A. J. Helou, M.D.   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>3-15-84   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HELOU J ABDALLAH MD  |  | 22e. ADDRESS<br>CHURCH HOSPITAL  |  | 100 N. BROADWAY BALTO. MD 21231   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3-20-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Rosary Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>John M. Webster 401 S. CHESTER ST.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  | REG. NO.   |       |
|--|--|---|--|---|---|---|--|--|--|--|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FREDERICK H KURTZ</b>   |  |   |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>84</b>                                |  | 2b. HOUR<br><b>3:00 P.M.</b>   |  |  |       |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>7</b> YEAR <b>01</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82 74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>7</b> DAYS <b>24</b> HOURS <b>4</b> MIN.  |  |  |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Unknown - MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |       |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unknown</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GASTROELECT</b>  |  |  |       |
| 13a. STATE<br><b>Unknown</b>   |  | 13b. COUNTY<br><b>Unknown</b>   |  | 13c. CITY OR TOWN<br><b>Unknown</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>99999</b>  |  |  |       |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>JOHN</b> LAST <b>KURTZ</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>AGUSTA</b> LAST <b>REIGH</b>   |   |   |  |  |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-6018</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>St. Charles MILTON KURTZ CAL</b>                                 |  |  |  |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>0381</b> IMMEDIATE CAUSE (a) <b>Cardiovascular arrest.</b>   |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b> |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |   |   |  |  |  | (b) <b>Staphylococcal sepsis.</b>                                |       |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |   |  |  |  | (c) <b>2 weeks</b>   |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Dementia</b>  |  |   |  |   |   |   |  |  |  |  |       |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY   | STATE |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>3/31</b> 19 <b>84</b> , to <b>3/31</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) |  |   |  |   |   |   |  |  |  |  |       |
| 22b. SIGNATURE<br><b>Ronald Sakamoto</b>   |  |   |  |   |   | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/31/84</b>                               |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronald Sakamoto</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>Mercy Hosp, 301 St. Paul Place, Baltimore 21202.</b>                         |  |  |  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>4/3/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD</b> |   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD</b> STATE   |  |  |       |
| 24. FUNERAL DIRECTOR<br>NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MACE</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 5 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Dana Lodonanga</i>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>3-4-84</i>  |   | 2b. HOUR<br><i>1:35 PM</i>  |  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>12 1 04</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>79</i>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <i>Poland</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hosp.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i> |
| 13a. STATE<br><i>Md.</i>  | 13b. COUNTY<br><i>Balto.</i>  | 13c. CITY OR TOWN<br><i>Balto.</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>607 Pennsylvania Ave.</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>unknown</i>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>unknown</i>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>no</i>  |   | 16b. SOCIAL SECURITY NO.<br><i>212343090A</i>  |   | 17. INFORMANT<br><i>Chart</i> ADDRESS<br><i>Bal.Md. 21201</i><br><i>Office of Aging 301 W.Preston S</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>5850</i> IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Bronchopneumonia</i><br>(c) <i>Chronic renal failure</i> |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Urinary Tract infection</i>  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 31</i> , 19 <i>84</i> , to <i>March 4</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>March 4</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |   |  |   |   |  |
| 22b. SIGNATURE<br><i>Cheng Chung</i>  |   | DEGREE<br><i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>CHENG CHUNG LCN</i>   |   | 22e. ADDRESS<br><i>730 Ashburton Ave<br/>Baltimore Md</i>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>  |   | 23b. DATE<br><i>March 8, 1984</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart of Jesus</i>                                      |  |
| 24. FUNERAL DIRECTOR<br><i>Mitchell-Wiedefeld Home</i>  |   | ADDRESS<br><i>6500 York Road</i>   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 8 1984</i>  |  |
|   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |                                       |  |   |  |  |  |  |
|--|--|--|--|---|---------------------------------------|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RAYMOND LAMB</b>                            |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 18, 1984</b>  |   |                                       | 2b. HOUR<br><b>M</b>   |   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 28 11</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                  |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b> |  | 7. UNDER 24 HRS.<br>HOURS MIN.<br><b>00 00</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b> |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>22 NORTH GORMAN AVENUE</b> |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>22 N. Gorman Ave. 21223</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lela Usher</b>  |                                       |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |  | 16b. SOCIAL SECURITY NO.<br><b>245-12-2389</b> |  | 17. INFORMANT<br><b>Dorothy M. Lamb</b>   |                                       |  |   | 17. ADDRESS<br><b>22 N. Gorman Avenue</b>    |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4/100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 16, 1984</b> , to <b>March 16, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Victor S. Roth</b>  |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/19/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VICTOR S. ROTH</b>   |  |  |  | 22e. ADDRESS<br><b>700 WASHINGTON BLYD BALTO 21230</b>   |  |   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b> |  | 23b. DATE<br><b>3/22/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owing Mills, Md.</b> |  |
|--|--|-----------------------------|--|---|--|---|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b> |  |
|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES GOVERNMENT  
OFFICE OF THE SECRETARY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |   |  |  |
|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Laurence F. LAMBDIN, SR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 8, 1984</b>                                 |   |  | 2b. HOUR<br><b>10:30am</b>  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 24 1940</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic-Crown</b>       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cork&amp;Seal</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1737 Stokesley Road 21222</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph J. Lambdin</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dolores E. Friedel</b>                  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-36-9883</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Ila M. Lambdin Same as 13e</b>                  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATO RENAL FAILURE</b><br><b>5719</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC LIVER DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>PERITONITIS</b> |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>January 23</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>March 8 19 84</b>      |   | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>March 8 19 84</b>      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 8 19 84</b> , to <b>March 8 19 84</b> , that (I) (we) lost saw the deceased alive on <b>March 8 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>A. F. Nazemi, M.D.</b>  |  |   |   |   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3/8/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. F. NAZEMI, M.D.</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 NORTH BROADWAY, BALTO., MD. 21231</b>                |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/12/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>                          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be called at once.

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CHAMPION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE R. LANDY</b> Landy   |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>24</b> YEAR <b>84</b>  |   | 2b. HOUR<br><b>5:25</b> AM   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>01</b> YEAR <b>1893</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US CITIZEN</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore city</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  |
| 13a. STATE<br><b>MD.</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. <b>3917 CLARKS LANE ( 21215)</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>JACOB</b> MIDDLE <b>ZEMIL</b> LAST <b>WALLACH</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>IDA</b> MIDDLE <b>WALLACH</b> LAST <b>WALLACH</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-19-8763-D</b>  |   | 17. INFORMANT<br><b>JESSIE Suttleman</b> ADDRESS <b>3600 Gabyrinth #21215 RD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe atherosclerotic cardio-vascular change?</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>30 min</b>  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>Hypertension Congestive heart failure</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>3/18/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute thrombosis of femoral artery</b>   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>84</b> , to <b>3/24</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>MARC SIEGELBAUM</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/24/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC SIEGELBAUM</b>  |  | 22e. ADDRESS<br><b>Sinai Hospital Balto. Md. 21215</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/25/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH CEM</b>   |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br><b>BALTIMORE, BALTIMORE, MD.</b>  |  | 23e. STATE<br><b>MD.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 28 1984</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Alia Davidson-Randall</b>   |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JUDGE E. EVERETT LANE</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 12, 1984</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 22 92</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>500 W. University Pkwy Apt 4R</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George M. Lane</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Nelson</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-36-6974</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Edna Hall Brown 2402 Montebello Terrace</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b><br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic squamous cell carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                     |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 months</b><br><b>Two years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/21, 1981</b> to <b>3/12, 1984</b> , that (we) lost<br>saw the deceased alive on <b>3/9, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (dd) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Donald W. Collins MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>3/14/84</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |
| 22e. ADDRESS   |  |   |  | 22f. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/16/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc, 1101 E North Avenue</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>14 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>   |  |

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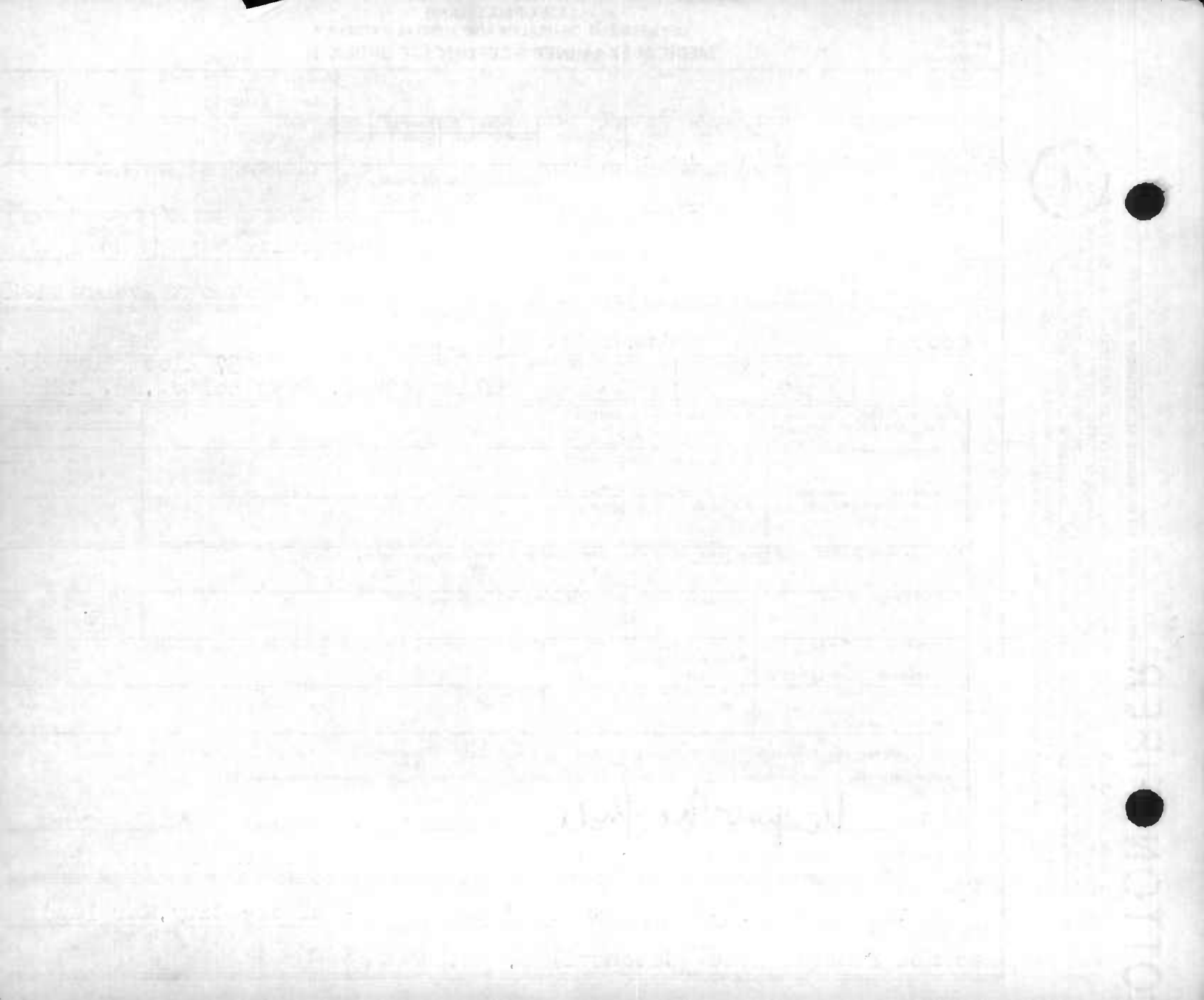
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |   |   |  |   |   |  |   | REG. NO.  |  |
|---|--|-------------------------|---|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGRET L. LARMORE</b>   |  |                         |   |   |  |   |   |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>3 8 1984</b>                  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 7, 1917</b>      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                   |   | 2b. HOUR <b>9:25 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b>  |  |                         |   |   |  |   |   |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>George Heinmueller</b>  |  |                         |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Laura Seidel</b>   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                      |  | 17. INFORMANT ADDRESS <b>37 Bloomsbury Av. Elizabeth E. Ways Balto., Md. 21228</b>  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                         |  |                         |   |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |   |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   |  |   | 20. AUTOPSY?<br>Body <input checked="" type="checkbox"/> Only <input type="checkbox"/><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |   |   |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |  |                         |   | TITLE (SPECIFY) <b>Assistant</b>                            |  |   |   | DATE SIGNED <b>3-9-84</b>  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                         |   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>              |  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                         | 23b. DATE <b>3/12/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>MacNabb Funeral Home Catonsville, Md.</b>   |  |                         |   |   |  | 25a. DATE REC'D BY REGISTRAR <b>MAR 13 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Lidia Dunder-Randall</b>                     |   |   |  |





**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |                         |  |   |  |   |  |   |  |
|---|--|-------------------------|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George D. Lauer</b>   |  |                         |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/><br>MONTH DAY YEAR<br><b>3-19 1984</b> |  |   |  | 2b. HOUR<br>M<br><b>8:43 a. M.</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 10 15</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68 YRS.</b>                             |  | 7. IF UNDER 1 YR. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7c. DATE PRONOUNCED DEAD<br><b>3-19 1984</b>  |  |                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Police Capt.</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore City Police Dept.</b>   |  |                         |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br><b>32 Dunmore Road</b>   |  |                         |  | 13f. ZIP CODE<br><b>21228</b>   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Lauer</b>   |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Carroll</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-10-3741</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret Lauer 32 Dunmore Road 21228</b>       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Diabetes Mellitus</b>   |  |                         |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED <b>3-19-84</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>3/22/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  |                         |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1984</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REMOTE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

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FORM  
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100-100000-1

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DHMH - 16 50M 1/B1  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07126

|   |  |   |  |  |     |  |          |
|---|--|---|--|--|-----|--|----------|
| 1. FOR<br>STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH  | DAY | YEAR   | 2b. HOUR |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE  |     | 5. DATE OF BIRTH   |          |
| FIRST MIDDLE LAST<br>Shelley Marie LAUER  |  | female  |  | white  |     | March 1, 1984  |          |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7a. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |     | 9. BALTIMORE CITY OR COUNTY OF DEATH   |          |
| Silver Spring, Md. U.S.A.   |  | U.S.A.  |  |  |     | Baltimore MD.  |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |     | 12b. KIND OF BUSINESS OR INDUSTRY  |          |
| Baltimore   |  | Baltimore City Hospital   |  | N/A  |     | N/A  |          |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |     | 13d. INSIDE CITY LIMITS?   |          |
| Md.   |  | A.A. Co   |  | Davidsonville  |     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |     | 17. INFORMANT<br>ADDRESS   |          |
| John Bernard  |  | Lauer Jr. Dianne  |  | no   |     | John B. Lauer same as 13e.   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u><br><u>7690</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BIRTH/PERINATAL ASPHYXIA WITH PFC, RESPIRATORY DISTRESS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>RENAL FAILURE</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |     |  |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                 |          |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |     |  |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |     |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>84</u> , to <u>3/6</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>Sharon Kay Peek MD</u><br>DEGREE   |  | 22c. DATE SIGNED<br><u>3/6/84</u>  |     |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Sharon KAY PEEK</u>   |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>   |  |  |     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>3/7/84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lakemont Gardens</u>  |     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Davidsonville A.A. Co. Md</u> |          |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Hardesty Funeral Home</u>  |  | 24b. ADDRESS<br><u>12 Ridgely Ave Annapolis, Md. 21401</u>  |  | 25. DATE REC'D. BY REGISTRAR 25b. <u>MAR 9 1984</u> <u>John Davidson-Randall</u>   |     |  |          |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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(3)

1000

MAR 9 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELMER WM. LAUPP</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MAR 21 1984</b>  |  |   |  | 2b. HOUR <b>12<sup>15</sup> M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Sept. 4, 1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>524 N. Charles Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Drug Clerk</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pharmaceutical</b>                |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>  |  |   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>524 N. Charles Street</b>                       |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick = Laupp</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Johanna = Mueller</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-0621</b>  |  | 17. INFORMANT<br><b>Marie Laup</b>  |  | ADDRESS<br><b>same as above</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (q)<br><b>Parkinson Disease &amp; Arteriosclerotic Cardiovascular Disease</b>  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 22, 1983</b> to <b>MAR 21, 1984</b> , that (I) (we) lost saw the deceased alive on <b>MAR 21, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Walter R. Welzant, M.D.</b>   |  |   |  |   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>MAR 21, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER R. WELZANT, M.D.</b>  |  |   |  |   |  |   |  | 22e. ADDRESS<br><b>MEDICAL ARTS BLDG BALTIMORE MD 21201</b>               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE<br><b>3/24/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem. Baltimore City, Maryland</b>        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>   |  |   |  |   |  | ADDRESS<br><b>Glen Burnie, Md.</b>  |  | 25a. DATE REC'D. BY REG. CLERK<br><b>MAR 23 1984</b>                      |  |  |  |

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RECEIVED

NOV 10 1964



U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filing in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07128

1. FOR  
STATE  
REGISTRAR

REG. NO.

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|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred K. Lawson   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 24 84                         |   |  | 2b. HOUR<br>12 <sup>26</sup> AM  |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 25 13  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Baltimore City  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hosp |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2398 Seamon Ave Apt. T. 21225 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Turner  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary                  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>218-14-3858                                |   | 17. INFORMANT ADDRESS<br>Lois Haynes 2603 Quantico Avenue                      |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coma<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sepsis disorder<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CVA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3d. |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Colon CA Gallbladder CA   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>3/16/84  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Colon CA           |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 23 March 1984, to 24 March 1984, that (1) (we) lost saw the deceased above (1) (we) (did not) view the body after death.  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>C. Coulter   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3/24/84  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Coulter   |  |   | 22e. ADDRESS<br>Bon Secours  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>3/29/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.  |  |   |  |   | ADDRESS<br>1101 E North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1984  |  |   |  |
|  |  |   |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |



1. The first part of the document discusses the importance of maintaining accurate records of all activities. It emphasizes that this is essential for ensuring the integrity of the data and for providing a clear and concise summary of the work done.

2. The second part of the document describes the various methods used to collect and analyze the data. It includes a detailed description of the experimental procedures and the results of the analysis.

3. The third part of the document discusses the implications of the findings and the conclusions drawn from the study. It highlights the significance of the results and the potential applications of the research.

4. The fourth part of the document provides a summary of the key findings and a list of references. It also includes a list of the authors and their affiliations.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07129

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JACOB LAZARUS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 2, 1984 |  |  | 2b. HOUR<br>P.M.<br>6:59  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 22, 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                     |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3601 FORDS LA., APT. 421 |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TAILOR                       |  | 15. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3601 FORDS LA., APT. 421 21215   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ZELIG LAZARUS  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>226-32-2480  |  | 17. INFORMANT<br>MR. SAM LAZARUS   |  | 8224 MARCIE DR. BALTO., MD  |  | 21208  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Age -  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> , 19_____, to <u>present</u> , 19_____, that (I) (we) lost<br>saw the deceased alive on <u>1983</u> , 19_____, and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                 |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Dana Frank</u> MS   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>         |  |   |  | 22c. DATE SIGNED<br>3/3/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DANA FRANK, MD  |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSP. - BALTO., MD   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>MAR. 4, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HAR SINAI  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>OWINGS MILLS BALTO. MD                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS. INC.<br>ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>MAR 6 1984   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>ANDERSON LEE  |  |  |  | 03-19-84 9:30 AM  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 22 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITALS |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>4800 Yellowwood Rd. Apt. 216 21209  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Green Lee  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lizzy Lee  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  |  |
| 16a. SOCIAL SECURITY NO.<br>216-07-8855   |  | 17. INFORMANT ADDRESS<br>Mary J. Lee 4800 Yellowwood Road  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>5989<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA / CNS SYPHILIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>URTICARIA STRICTURE → SEPSIS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>84</u> , to <u>3/19</u> , 19 <u>84</u> , that (we) lost saw the deceased alive on <u>3/19</u> , 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>do not</u> (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Andrew Yang M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3-19-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANDREW YANG M.D.   |  |  |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITALS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/24/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. National Mem Pk   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Laurel Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H Inc. 1101 E North Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 21 1984  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |  |  |  | 25c. REGISTRAR'S SIGNATURE<br>John Davidson   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07131

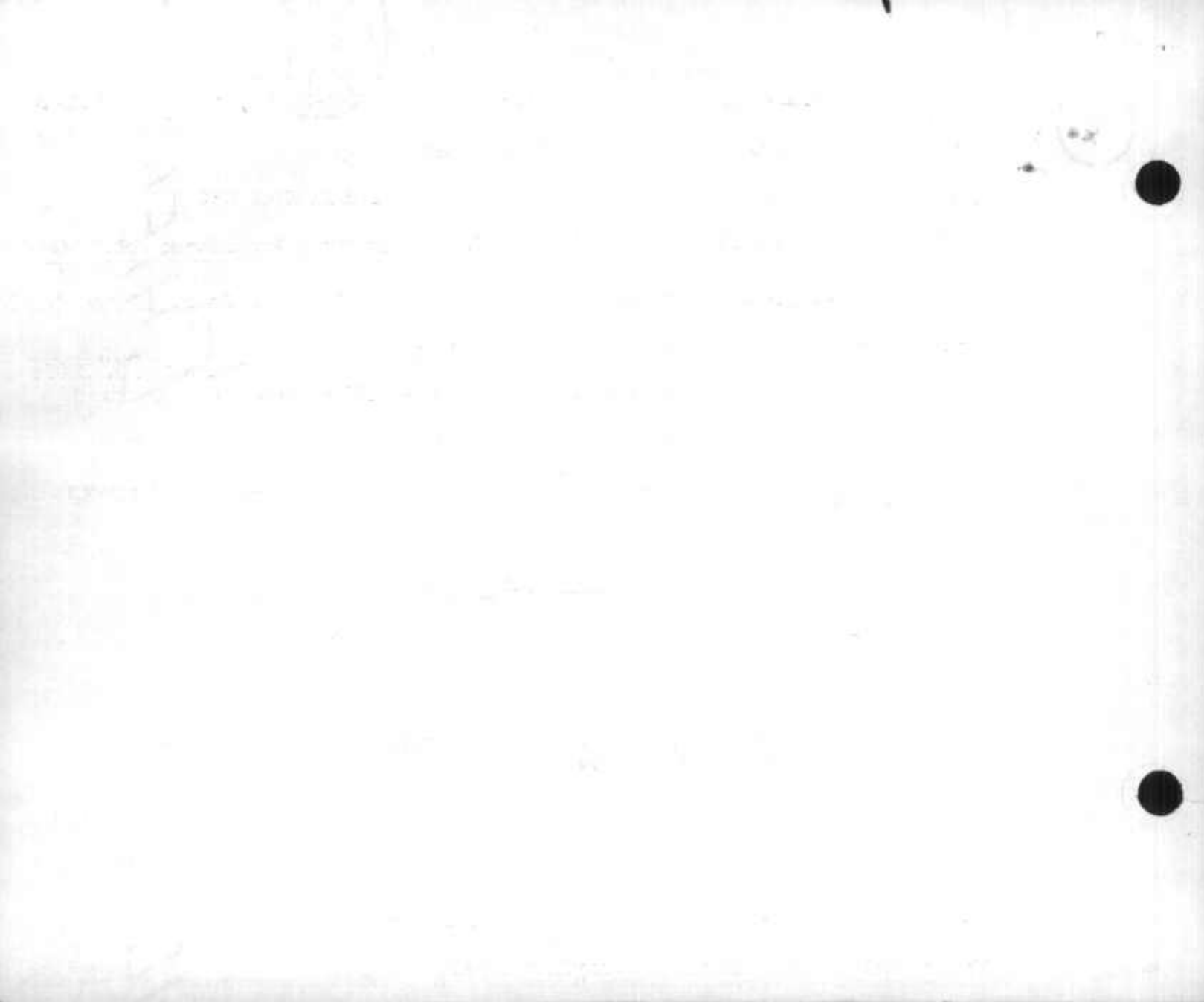
FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |   |  |                                   |  |
|--|--|---|--|---|---|---|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANGELA CHIN LIN LEE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 28, 1984                  |   |   | 2b. HOUR<br>8:20 A.M.   |   |  |                                   |  |
| 1. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 26, 1943  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>China   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                              |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>JOHNS HOPKINS HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Computer Programmer |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>VITRO CORP.   |                                   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Potomac  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>TZE-QUEI LIN   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SHAO-HWA WANG         |   |   | 16. SOCIAL SECURITY NO.<br>467-90-5665  |   |  | 17. ADDRESS<br>Potomac, Md. 20854 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>467-90-5665                                |   |   | 17. INFORMANT<br>Henry W. Lee; 10916 Broad Green Terrace;                               |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>metastatic Breast Carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>3 years |  |   |  |   |   |   |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)            |   |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> , 19 <u>84</u> , to <u>3/28</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |  |                                   |  |
| 22b. SIGNATURE<br><u>Stephen C Redd</u> MD   |  |   |  |   | 22c. DATE SIGNED<br>3/28/84   |   | 22d. ADDRESS<br>600 N. Wolfe St. Baltimore, MD 21205  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>3/31/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cemetery; Silver Spring; Montg.; Md. |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                                   |  |
| 24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS<br>NAME ADDRESS<br>1170 Rockville Pike; Rockville, Maryland 20854   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 4 1984   |   |   |  |                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2  
remained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07132

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                             |  |   |   |  |                          |  |
|--|--|---|--|---|-----------------------------|--|---|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARSHALL H. LEE       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/25/84               |   |                             | 2b. HOUR<br>8:15p.m.   |   |   |  |                          |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 28 27   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS                |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Key Circle Hospice |  |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chauffeur                          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING |  |                          |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto. |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>2526 Calverton Hgts. 21216 |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert E. Lee, Sr. |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Thomas |   |                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   |   |  | 16b. SOCIAL SECURITY NO. |  |
| 17. INFORMANT<br>Mrs. Beatrice Greene                        |  |   | 18. ADDRESS<br>2526 Calverton Hgts.                          |   |                             |  |   |   |  |                          |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LOST.<br>(b) CARDIO PULMONARY ARREST<br>CARCINOMA OESOPHAGUS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

COPD

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>N/A   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>N/A   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>N/A   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 3-24, 1984, to 3-25, 1984, that (I) (we) lost<br>saw the deceased alive on 3-24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Singer - A. J. ...  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/26/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SURTIT JULKA   |  |  |  | 22e. ADDRESS<br>107-109 E Saratoga St Baltimore 21201  |  |   |  |

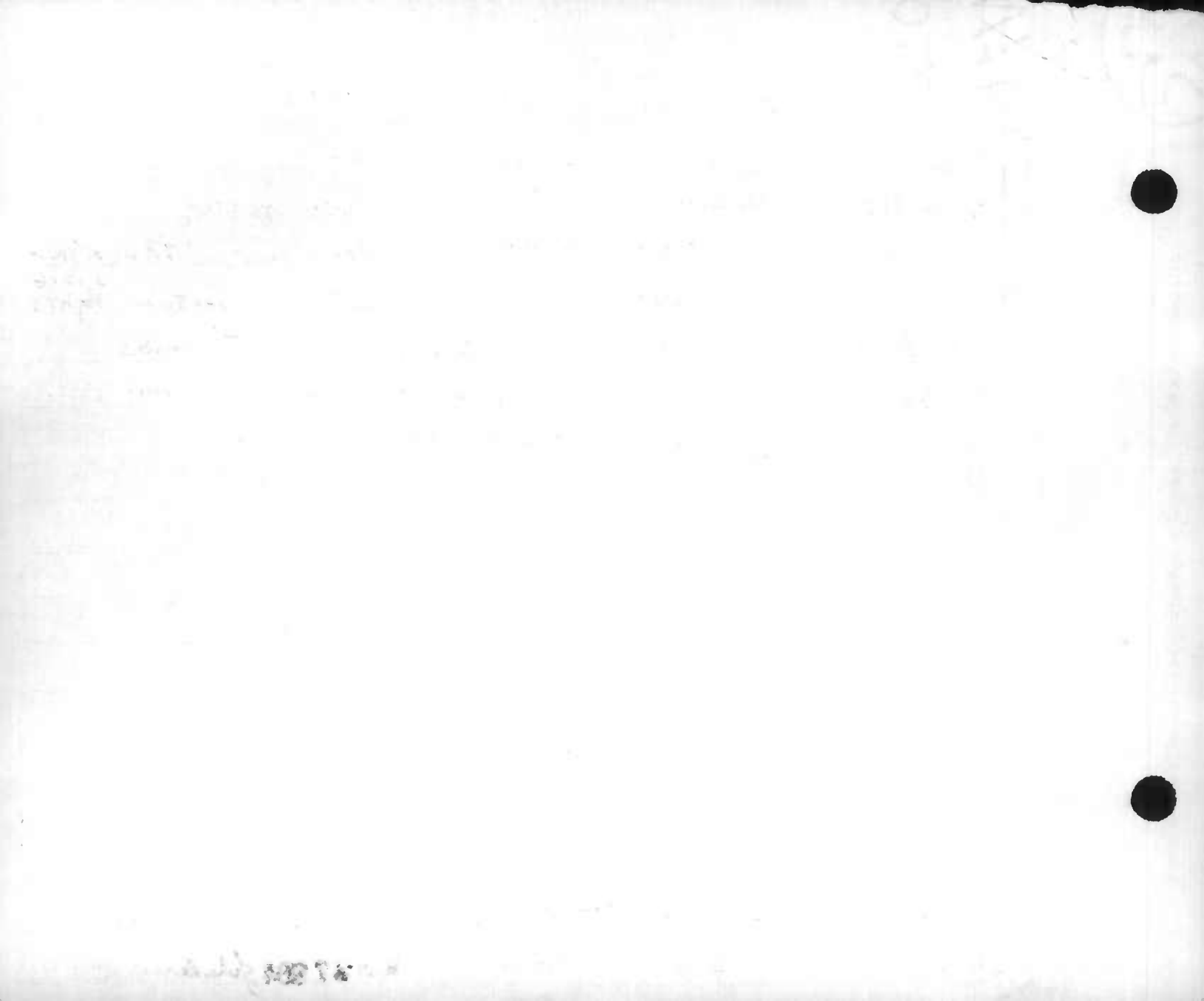
|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                             |  | 23b. DATE<br>3-29-84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. Auburn |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>James A. Morton & Sons 1701 Laurens Street |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1984     |  | 25b. REGISTRAR'S SIGNATURE<br>John Anderson Randall      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07133

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |  |
|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary FRANCES Lee</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03/16/84</b> |   |  | 2b. HOUR<br><b>200 P M</b>  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>N</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 20 29</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp. of Balto.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |   |  |   |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>4008 Belview Ave 21215</b>   |  |   |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Edward Jacobs</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Manokey</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT ADDRESS<br><b>Norrine Parker 7 Stonemark Court</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple 3 vessel cerebral throm-</b><br><b>4340</b> DUE TO, OR AS A CONSEQUENCE OF <b>bosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>17 days</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Staph sepsis</b>  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> 19 <b>84</b> , to <b>3/16</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/16</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>m j Gover md</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/16/84</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gover.</b>   |  |   |   | 22e. ADDRESS<br><b>Sinai Hosp of Balto.</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/22/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Md.</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>   |  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Randall</b>  |  |   |   | 25c. REGISTRAR'S NAME<br><b>Randall</b>   |  |   |  |  |

THE UNIVERSITY OF CHICAGO  
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CHICAGO, ILL. 60637



CHICAGO

FOOK COLLEGE

MAR 5 1984

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07134

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN T LEFF</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>03</b> YEAR <b>84</b> |  |  | 2b. HOUR<br><b>9:03PM</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>6</b> YEAR <b>1944</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39</b> YRS.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPED WORK FOR AND HOW WORKING LIFE)<br><b>Recruiter</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Armed Forces</b>  |  | 13a. STREET ADDRESS / ZIP CODE<br><b>Rt. 3 Box 639L 70433 98989</b>  |   |  |  |  |  |
| 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. CITY OR TOWN<br><b>Covington</b>  |   | 13d. STREET ADDRESS / ZIP CODE<br><b>Rt. 3 Box 639L</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Rt. 3 Box 639L</b>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Gerald</b> MIDDLE <b>Leff</b> LAST <b>Bright</b>                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Janet</b> MIDDLE <b>Bright</b> LAST <b>Bright</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>Vietnam</b>                       |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>424-56-4830</b>  |  | 17. INFORMANT<br><b>Penny Phillips Leff</b> ADDRESS <b>Rt. 3 Box 639L Covington, Louisiana</b>   |   |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 minutes**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Leukemia**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

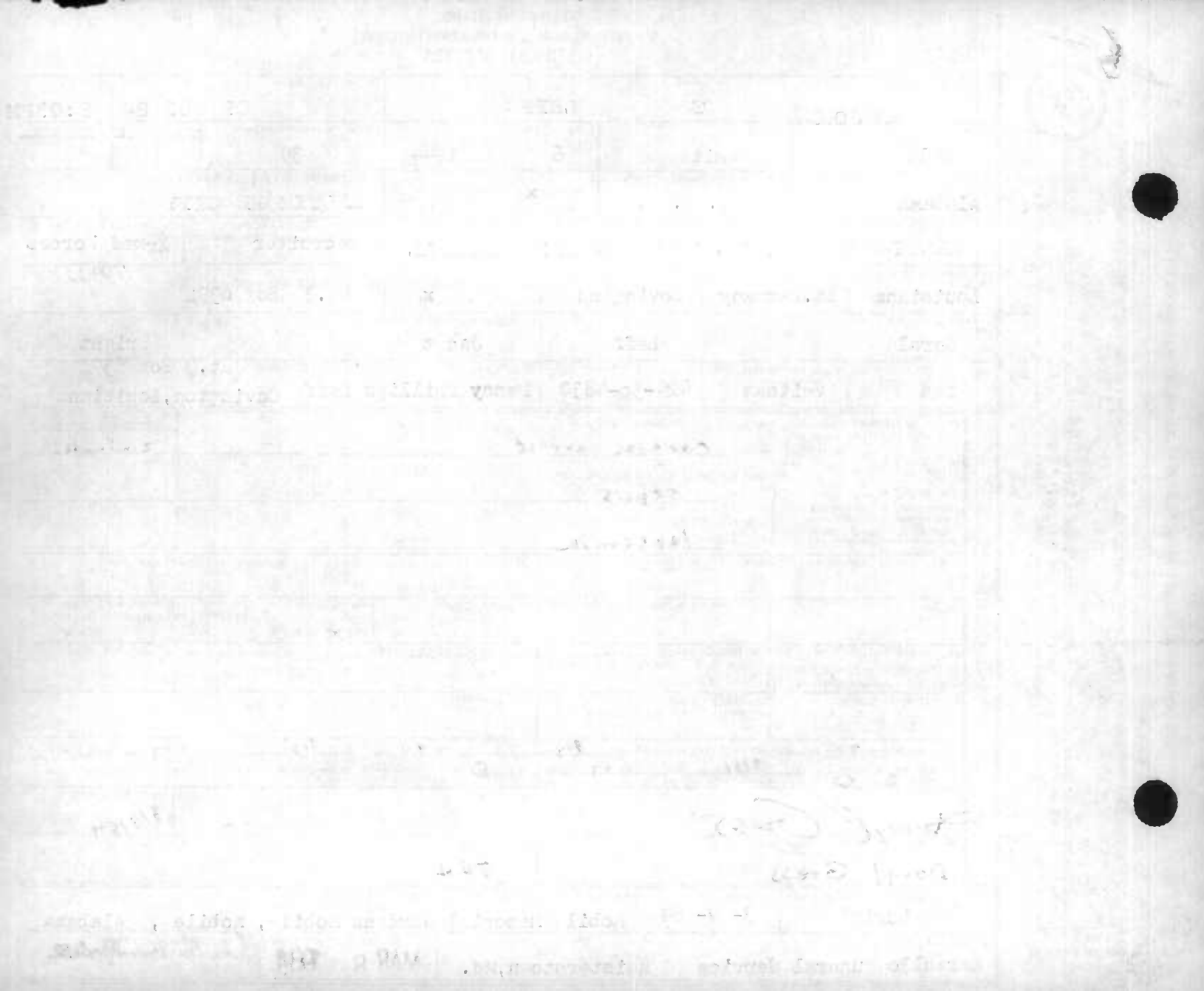
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2/4</b> , 19 <b>84</b> , to <b>3/3</b> , 19 <b>84</b> , that (we) last<br>saw the deceased alive on <b>3/31</b> , 19 <b>84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Daryl Gress</b><br>THE PHYSICIAN'S NAME (TYPE OR PRINT)  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3/3/84</b>  |  |
| 22d. ADDRESS<br><b>JHN</b>  |  |  |  |  |  |  |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>      |  | 23b. DATE<br><b>3-9-84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mobile Memorial Gardens Mobile, Alabama</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marzullo Funeral Service</b> |  |                            |  | ADDRESS<br><b>Reisterstown, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 8 1984</b> |  |
|   |  |                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b>                           |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 7 1 3 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |   |  |  |  |
|---|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CATHERINE EVELYN LEITNER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 1, 1984</b>            |   |   | 2b. HOUR<br><b>10:30am</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/ 13/ 1908</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>JOHNSTOWN, PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITALS</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSE PARENT</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CHILDREN'S HOME</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>6923 BELCLARE ROAD 21222</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PETER J. RILEY</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA MCNAMARA</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>820.04.6588</b>   |  | 17. INFORMANT<br><b>WILLIAM M. SMITH</b>  |   | ADDRESS<br><b>14002 BURNIWOODS ROAD<br/>GLENELG, MD. 21737</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>C.R.E.S.T. Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Arthur E. Cocco, M.D.</b>  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-2-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS<br><b>20 E. EAGER ST. BALTO., MD. 21203</b>               |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>3/5/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART OF JESUS DUNDALK, BALTO., MD.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>   |  |  | ADDRESS<br><b>21222</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1984</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Gina Davidson</b> |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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2000

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2002

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07136

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frances Loretta Lemmon</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 29 84</b> |   | 2b. HOUR<br><b>12:05 A<sub>M</sub></b> |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 10 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | 8. UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6000 Bellona Avenue</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical</b>                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>                                |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6000 Bellona Ave., 21212</b>                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luke P. McGuire</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beatrice O'Connor</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No -</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>216-03-7723</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sally Lemmon, 1730 Edgewood Rd., 21234</b>                                |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Coronal Disease</b><br><b>4370</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2+ yrs</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chr. Leucemy - heart infection</b>  |  |   |   |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                           |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 26 1984</b> to <b>July 22 1984</b> , that (I) (we) last saw the deceased alive on <b>Nov 26 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED<br><b>3-30-84</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick J. Vollmer, M.D.</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>6100 York Rd., Towson, Md. 21204</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |   | 23b. DATE<br><b>3/31/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Md.</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. E. Lowell Lemmon</b> ADDRESS<br><b>10 W. Padonia Rd.</b>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 2 - 1984</b> REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |  |  |   |                                   |  |   |  |  |  |  |
|---|--|--|--|---|-----------------------------------|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEONARD, BABY GIRL "A"</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-5-84</b> |   |                                   | 2b. HOUR<br><b>4:12 A.M.</b>   |   |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-4-84</b>   |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>11 48</b>          |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT. City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp</b> |  |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>-</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b> |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>                          |   | 13c. CITY OR TOWN<br><b>ESSEX</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>943 BARRON AVE</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD LEONARD</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KELLY HASLUP</b>  |                                   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |                                   | 17. INFORMANT<br>ADDRESS<br><b>PARENTS ABOVE</b>                             |   |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

7690 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Respiratory Distress Syndrome**

DUE TO, OR AS A CONSEQUENCE OF  
(c) **Prematurity (24 weeks)**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

11 hr 48 min

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-4-84</b> to <b>3-5-84</b> , that (I) (we) last saw the deceased alive on <b>3-5-84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we last did not view the body after death) |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Jacob K Felix</b> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-5-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jacob K Felix</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/8/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>  |  |

24. FUNERAL DIRECTOR

NAME  
**J G. CONNELLY**

ADDRESS  
**300 MACE**

25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE

**MAR 9 1984** **J. Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

324-7453

12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07138

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |  |   |   |   |  |
|--|--|---|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Baby Girl Leonard</i>                   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-5-84</i>                 |  |  | 2b. HOUR<br><i>12:10 PM</i>  |   |   |   |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 4 84</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>— — 20</i> |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U S A</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD.</i>    |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hosp.</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |   | 12b. KIND OF BUSINESS OR INDUSTRY                 |   |  |
| 13a. STATE<br><i>MD.</i>   |  |   | 13b. COUNTY<br><i>BALTO</i>  |  | 13c. CITY OR TOWN<br><i>ESSEX</i>                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>943 BARRON AVE 21221</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>EDWARD LEONARD</i>                |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>KELLY HASLUP</i> |  |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i> |  |   | 16b. SOCIAL SECURITY NO.<br><i>NONE</i>                              |  | 17. INFORMANT<br>ADDRESS<br><i>PARENTS ABOVE</i> |  |   |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*7690*Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT HOME21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from *3-5-84* to *3-5-84*, that (I) (we) lost  
saw the deceased alive on *3-5-84*, and that in my (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) (did not) view the body after death.

22b. SIGNATURE

*Jacob K. Felix*22c. DATE SIGNED  
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STATE PHYSICIAN ☐

22d. ADDRESS

*Sinai Hospital*23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)*BURIAL*

23b. DATE

*3/8/84*

23c. NAME OF CEMETERY OR CREMATORY

*OAK LAWN*23d. LOCATION  
CITY OR TOWN*BALTO.*

COUNTY

*MD*

STATE

24. FUNERAL DIRECTOR

NAME

*J.G. COMVELL*

ADDRESS

*300 MACE*

25a. DATE REC'D. BY REGISTRAR

*MAR 9 1984*

25b. REGISTRAR'S SIGNATURE

*John Davidson-Randall*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07139

1- STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |   |  |
|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA T. LEWANDOWSKI</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>03 - 28 - 84</b>                 |  |   | 2b. HOUR <b>1248 P M</b>  |  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 - 31 - 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                       |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. STATE<br><b>md.</b>   |   |   | 13b. COUNTY<br><b>—</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Kemp</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Carr</b> |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b> |   |   | 16b. SOCIAL SECURITY NO.<br><b>215-03-0653</b>                       |  | 17. INFORMANT ADDRESS<br><b>21. Boeck 58 G. H.</b>  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4860**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-28-84</b> to <b>3-28-84</b> , that (I) (we) last saw the deceased alive on <b>3-28-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Henry Boeck</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-28-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. BOECK</b>   |  |  |  | 22e. ADDRESS<br><b>SOUTH BALTIMORE GENERAL</b>   |  |   |  |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Buried</b>               | 23b. DATE<br><b>3/31/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Restvale Memorial</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Towson Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CHARLES L. STEUBINS FUNERAL HOME INC</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1984</b>            |   |
| ADDRESS<br><b>1501 E FOLT RD BALTO MD.</b>                                  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Judith Davidson-Randall</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07140

REG. NO.

|  |  |   |  |   |                                |   |   |  |  |
|--|--|---|--|---|--------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Carroll T. Lewis  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 7, 1984               |   |                                | 2b. HOUR<br>4:36 PM   |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 21, 1903   |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan 21239 |  |   |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Baltimore                                       |   | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Lewis  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Miles |   |                                | 13e. STREET ADDRESS<br>2806 Rosalie Ave. 21234                            |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Unk.   |  | 17. INFORMANT<br>Mr. Doug Lewis - RD #2, Box 307A-Glenrock, Pa.   |                                | 17b. ADDRESS<br>17327   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |                                |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 YEARS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Diabetes Mellitus; Carcinoma of the Colon   |  |   |  |   |                                |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 04-21, 19 81, to 03-07, 19 84, that (I) (we) last saw the deceased alive on 02-07, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.    |  |   |  |   |                                |   |   |  |  |
| 22b. SIGNATURE<br>Anthony G. Lewandowski   |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                                |   |   | 22c. DATE SIGNED<br>03-08-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. TXXX Lewandowski  |  |   |  | 22e. ADDRESS<br>7402 York Road  |                                |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/10/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard County               |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz Funeral Home - 3818 Roland Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |                                | 25b. REGISTRAR'S SIGNATURE<br>John T. Anderson                            |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 07141   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JAMES C LEWIS  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 24 84   |  | 2b. HOUR<br>1:25P M   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 29 25  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3803 Barrington Road 21215   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Lewis  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eva Christian   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>218-18-0454  |  | 17. INFORMANT ADDRESS<br>Edna Lewis 3803 Barrington Road  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) ANOXIAL ENCEPHALOPATHY<br>DUE TO, OR AS A CONSEQUENCE OF (c) CARDIORESPIRATORY ARREST  |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 24, 1984, to March 27, 1984, that (I) (we) last saw the deceased alive on March 24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Walter Royal  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>3/24/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER ROYAL II, MD  |  |  |  | 22e. ADDRESS<br>2600 LIBERTY HIGHTS.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/29/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Owings Mills Md.                                     |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H Inc.  |  |  |  | ADDRESS<br>1101 E North Avenue  |  | 25a. DATE OF DEATH<br>MAR 27 1984   |  | 25b. REGISTRAR SIGNATURE<br>Kendall  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07142

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE   |  |
| MATTHEW LEWIS  |  | Male   |  | Black   |  |
| 5. DATE OF BIRTH   |  | 6. AGE   |  | 7. BIRTHPLACE   |  |
| MONTH DAY YEAR<br>12 20 33   |  | 50 YRS.  |  | Md.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH   |  |
|  |  | BALTIMORE CITY   |  | BALTIMORE   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| UNION MEMORIAL HOSPITAL  |  | (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Md.  |  |  |  | Balto.  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. AS DECEASED EVER IN U.S. ARMED FORCES?  |  |
| Thomas Lewis   |  | Unkn   |  | Yes <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 17. INFORMANT  |  | ADDRESS  |  | 18. CAUSE OF DEATH  |  |
| Mildred Lewis  |  | 2553 Robb St.  |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>septic shock 2° sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADENOCARCINOMA OF LUNG</u> |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED  |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 25/</u> , 19 <u>84</u> , to <u>March 8</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March 8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| YVETTE OQUENDO M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 3/8/84  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| (SPECIFY)  |  | 3/12/84  |  | Garrison Forest VA  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Wm C March F.H.  |  | 1101 E. North Ave.   |  | MAR 13 1984 Julia Davidson-Randall  |  |

page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



RECEIVED  
FEB 10 2000

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07143

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leon LIBERMAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 13, 1984</b>                             |  | 2b. HOUR<br><b>1:15P M</b>                        |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 11, 1921</b>                 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASSACHUETTS</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.            |   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br><b>MARYLAND</b> |  |   | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF-EMPLOYED</b> |  | 12c. KIND OF BUSINESS OR INDUSTRY<br><b>SALES</b> |  |
| 13a. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>4220 NADINE DR. 21215</b>               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SOLOMON LIBERMAN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA UNKNOWN</b>                     |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>010-07-2660</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. HELEN LIBERMAN 4220 NADINE DR. 21215</b> |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**45 minutes**

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF  
(b) **Acute Myocardial Infarction**

**45 Minutes**

DUE TO, OR AS A CONSEQUENCE OF  
(c) **Coronary atherosclerosis**

**10 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**System Hypertension Valvular heart disease**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1972</b> , 19____, to <b>March 13</b> , 19 <b>84</b> , that (we) lost<br>saw the deceased alive on <b>March 13</b> , 19 <b>84</b> , and that in (my) <b>xxx</b> opinion death occurred on the date and hour and from the causes stated<br>above. (If (this) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Daniel Lindenstruth M.D.</b>  |  |  |  | 22c. DATE SIGNED<br><b>3/13/84</b>   |  | 22d. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel Lindenstruth, M.D.</b>  |  |  |  | 22f. ADDRESS<br><b>c/o Maryland General Hospital</b>                                 |  |   |  |

MEDICAL CERTIFICATION

1

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/15/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMENS CIRCLE CEM</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1984</b>              |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Felia Davidson-Rendall</b>   |  |                             |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with a local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

157

March 13, 1984

LIBRARY

Leon

Maritime City

Maritime General Hospital

Maritime

45 minutes

Cardiovascular system

45 minutes

Acute Myocardial Infarction

10 years

Coronary atherosclerosis

Vascular heart disease

Ischemic heart disease

x

xx 04

March 13

1972

xx

March 13

xx

3/13/84

xx

c/o Maritime General Hospital

David Lindemann, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 07144  |  |   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><b>LIZZIE Williams Lifford</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/31/84</b>  |  |   |  | 2b. HOUR<br>DAY MONTH<br><b>10<sup>15</sup> M</b> |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 10 1926</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>31 84</b>  |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.<br><b>10<sup>15</sup> M</b> |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2700 Ulman Avenue<br/>Baltimore, Maryland 21215</b>  |  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Iran Williams</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lola Carroll</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>249-34-1147</b>   |  |   |  |   |  |  |  |
| 17. INFORMANT<br><b>Bernice Byrd</b>   |  | ADDRESS<br><b>Baltimore, Md. 21215 Ave.</b>  |  |   |  |   |  |  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) METASTATIC SMALL CELL CARCINOMA OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>84</b> , to <b>3/31</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Nisha Soprey</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED   |  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NISHA SOPREY</b>   |  |  |  | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL<br/>2600 LIBERTY HEIGHTS, BALTO</b>   |  |   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/7/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc.<br/>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 4 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |  |  |

BP

Letter & Sons Funeral Home Inc.  
Mt. Auburn Cemetery, Boston, MA 02138

3-11-53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |                          | 07145  |  |
|---|--|---|--|---|--|---|--|--|--------------------------|--|--|
| 1 - FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |                          |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>GEORGE</u> MIDDLE <u>RUSSELL</u> LAST <u>LILLY</u><br><i>George Russell Lilly</i>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>27</u> YEAR <u>84</u>                                   |  |  | 2b. HOUR <u>10:50</u> PM |  |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>WHITE</u>   |  | 5. DATE OF BIRTH MONTH <u>01</u> DAY <u>19</u> YEAR <u>08</u>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><u>76</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>   |                          | IF UNDER 24 HRS.<br>HOURS <u></u> MIN. <u></u>                 |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                               |  |  |                          |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>ST. AGNES HOSPITAL</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>SUPERVISOR</u>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>RAILROAD</u>   |                          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MARYLAND</u>  |  | 13b. COUNTY <u>HOWARD</u>   |  | 13c. CITY OR TOWN<br><u>ELKRIDGE</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>5922 OLD WASHINGTON RD., 21227</u>  |                          |  |  |
| 14. FATHER'S NAME FIRST <u>ROBERT</u> MIDDLE <u>H.</u> LAST <u>LILLY</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>ELEANOR</u> MIDDLE <u></u> LAST <u>GREEN</u>  |  |   |  |   |  |  |                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>NO</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>215-09-2288</u>  |  | 17. INFORMANT ADDRESS<br><u>AGNES M. LILLY 5837 TIMBERVIEW DRIVE, 21227</u>   |  |   |  |  |                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4029</u> IMMEDIATE CAUSE (a) <u>Stroke - Poss. Left middle Cerebral Artery 1/24</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive arteriosclerotic</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years -</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Indeterminate adenocarcinoma prostate</u>  |  |   |  |   |  |   |  |  |                          |  |  |
| 19a. DATE OF OPERATION<br><u>March 8 / July 21</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>to prostate</u><br><u>Arteriosclerotic by per</u>                            |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u></u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>74</u> , to <u>March 27</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March 27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |                          |  |  |
| 22b. SIGNATURE<br><u>Alexander L. Jones MD</u>  |  | DEGREE<br><u>MD</u>   |  |   |  |   |  | 22c. DATE SIGNED<br><u>3/27/84</u>   |                          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Alexander L. Jones</u>  |  | 22e. ADDRESS<br><u>1900 Selphur Spring Rd Baltimore 21229</u>   |  |   |  |   |  |  |                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>03-31-84</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MEADOWRIDGE MEM. PK.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>ELKRIDGE HOWARD MARYLAND</u>                   |  |  |                          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>HUBBARD FUNERAL HOME, INC.</u>   |  | ADDRESS<br><u>4107 WILKENS AVE.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 29 1984</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Davidson</u>  |  |  |                          |  |  |

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RECEIVED

MAR 29 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | 07146  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>BISHOP Jose SIMON Linares  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 7 84   |  | 2b. HOUR<br>8 <sup>55</sup> M   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 2 98   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BoyotaColumbia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>S.America   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital of Maryland |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1530 N. Smallwood St. 21216                        |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>- - -   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>- - -   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>Antoniette Morgan 1530 N. Smallwood St.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4860 SHOCK (ARRHYTHMIA)<br>DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-29-84, 19, to 3-7-84, 19, that (I) (we) last saw the deceased alive on 3-7-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  | 22c. DATE SIGNED<br>3-7-84   |  |
| 22b. SIGNATURE<br>Edward W. Schaefer   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-7-84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD W. SCHAEFER, JR. M.D.  |  |   |  |   |  | 22e. ADDRESS<br>730 ASHBURTON ST. BALT. MD. 21216  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>3/12/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garden of Eternal Hope   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.             |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                       |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07147

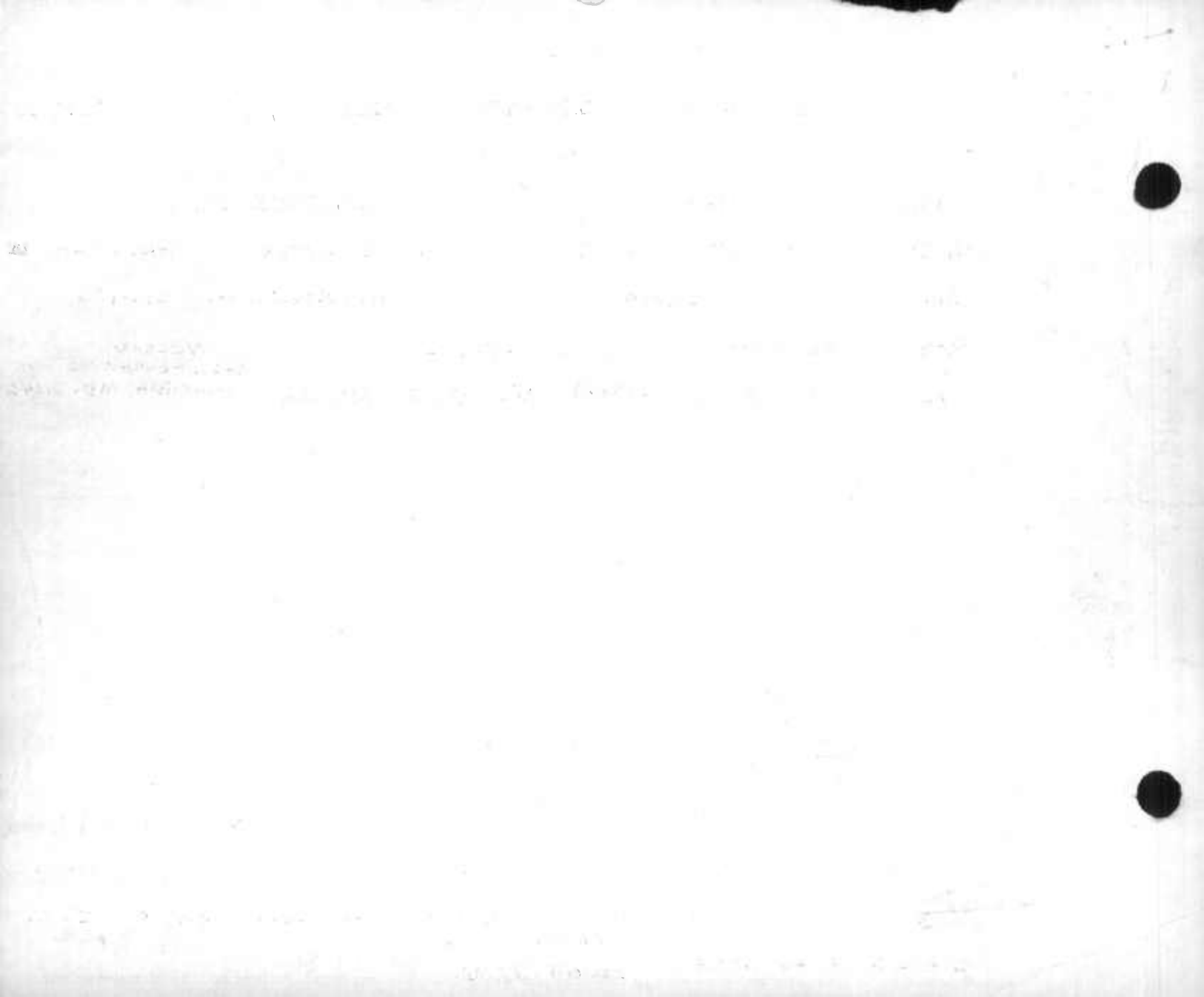
|   |                  |   |   |
|---|------------------|---|---|
| FOR<br>STATE<br>REGISTRAR   |                  | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARVIN MILFORD LINDBLOM   |                  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 09, 1984  |   |
| 2b. HOUR<br>05:20 AM  |                  |   |   |
| 1. SEX<br>MALE  | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 21 1923   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL   |                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ENGINEER  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>RAILROAD   |                  |   |   |
| 13a. STATE<br>ILL.  |                  | 13b. COUNTY<br>KNOX   | 13c. CITY OR TOWN<br>GALESBURG  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                  | 13e. STREET ADDRESS / ZIP CODE<br>1254 N. PRARIE ST. 61461  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROY MILFORD LINDBLOM  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GENEVA NELSON  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |                  | 16b. SOCIAL SECURITY NO.<br>328-16-2879   |   |
| 17. INFORMANT<br>M's DEE MILLER   |                  | ADDRESS<br>6422 BEECHWOOD AVE<br>COLUMBIA, MD. 21046  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Lung Cancer (Adenocarcinoma)<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 months   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                  |   |   |
| 19a. DATE OF OPERATION<br>none  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>none  |   |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from February 27, 1984, to March 9, 1984, that (I) (we) last saw the deceased alive on 3/9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |                  |   |   |
| 22b. SIGNATURE<br>Stephen C. Redd, M.D.   |                  | 22c. DATE SIGNED<br>3/9/84  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen C. Redd  |                  | 22e. ADDRESS<br>600 N Wolfe St, Baltimore, MD 21205   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>3-13-84  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN MEM. GVN.  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GALESBURG KNOX ILL.   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>SLACK FUNERAL HOME  |                  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1984  |   |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |                  |   |   |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. BEESTON ST., BALTIMORE, MARYLAND 21201

208 63 58  
03/11/83  
HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be filed with a burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07148

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |   |  |   |  |
|---|--|---|--|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER G. LITCHFIELD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/15/84</b>                                |   |   | 2b. HOUR<br><b>4.30 AM</b>   |   |  |   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 21 1914</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Pressman</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Venetian Blind</b>   |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>1</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3767 Ravenwood Cve. 21213</b> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Everett Litchfield</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora France</b>                  |   |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>220-05-8331</b>                                       |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Pauline Litchfield 3767 Ravenwood Ave 21213</b> |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOTENSION &amp; BRADYCARDIA</b><br><b>5728</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>LIVER FAILURE, RENAL FAILURE, ALCOHOL ABUSE.</b> |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>DISSEMINATED INTRAVASCULAR COAGULATION; URINARY TRACT INFECTION</b>  |  |   |  |   |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>3/2/84</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INTRA-ABDOMINAL SEPSIS</b>    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>N/A</b> <b>19</b>         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b> |   |  |   |  |   |  |
| 21d. INJURY OCCURRED <b>N/A</b><br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>                              |   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> 19 <b>84</b> , to <b>3/15</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Jean K. Janda M.D., M.P.H.</b>   |  |   |  |   |   | DEGREE<br><b>M.D., M.P.H.</b>  |   | 22c. DATE SIGNED<br><b>3/15/84</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEAN K. JANDA M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/17/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc</b>   |  |   |  |   |   | ADDRESS<br><b>5305 Harford Rd. 21214</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1984</b>   |   |  | 26. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b> |  |

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(VRA 15, 4) 7/78

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MEMORANDUM

TO : THE SECRETARY

FROM : THE SECRETARY

DATE : 10/17/54

SUBJECT : [illegible]

[illegible]

[illegible]

[illegible]

10/17/54

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

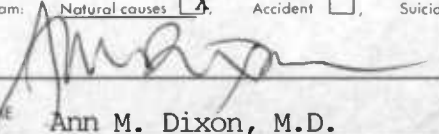
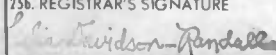
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                  |  |  |   |  |   |      |                                       |  |   |  |  |               |   |  |  |  |
|--|--|------------------|------------------|--|--|---|--|---|------|---------------------------------------|--|---|--|--|---------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>MICHAEL |  |  | MIDDLE<br>LIVANI                              |  |   | LAST |                                       |  | 2a. DATE OF DEATH<br>KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 2 2 1984          |  |  | 2b. HOUR<br>M |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>79 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |      | 7c. DATE PRONOUNCED DEAD<br>4 23 1984 |  | 2d. HOUR<br>1:17 P M  |  |  |               |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |      |                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |               |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2919 Alvarado Square |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |      |                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |               |   |  |  |  |
| 13a. STATE<br>Md.  |  |                  |                  | 13b. COUNTY<br>Balto.  |  |   |  | 13c. CITY OR TOWN<br>Balto.   |      |                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> 2 1/2                          |  |  |               | 13e. STREET ADDRESS<br>2919 Alvarado Square 21234 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |      |                                       |  |   |  |  |               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                  |                  | (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>181-20-4318   |      |                                       |  | 17. INFORMANT ADDRESS   |  |  |               |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |                  |                  |  |  |   |  |   |      |                                       |  |   |  |  |               |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |                  |  |  |   |  |   |      |                                       |  |   |  |  |               |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |      |                                       |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |               |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)   |      |                                       |  |   |  |  |               |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |                                       |  |   |  |  |               |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                  |  |  |   |  |   |      |                                       |  |   |  |  |               |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                  |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED 4-24-84   |      |                                       |  |   |  |  |               |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                  |                  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |   |  |   |      |                                       |  |   |  |  |               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  |                  |                  | 23b. DATE<br>4/30/84   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |      |                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |               |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board ADDRESS<br>Balto., Md.   |  |                  |                  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1984   |      |                                       |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |               |   |  |  |  |



SECTION 101-10

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner or the medical examiner's representative should be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   | REG. NO. 07150   |  |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR <b>HERMAN A. LOETZ</b>   |   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HERMAN LOETZ</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3 5 84</b>   |  | 2b. HOUR <b>8:45 AM</b>                      |
| 3. SEX <b>M</b>   | 4. RACE <b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 16 17</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.                                       |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South BALTIMORE Gen. Hosp.</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Letter Carrier</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>MD</b>   | 13b. COUNTY <b>A.A.</b>   | 13c. CITY OR TOWN <b>PASADENA</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <b>8116 EDGEWATER RD.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>HERMAN LOETZ</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>LILIAN FINMAN</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>  |   | 16b. SOCIAL SECURITY NO. <b>214-05-3923</b>   |   | 17. INFORMANT ADDRESS<br><b>Margaret Loetz (same as 13e)</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GASTRIC CANCER</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10/84</b> , 19____, to <b>3/5/84</b> , 19____, that (I) (we) lost saw the deceased alive on <b>3/5/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Daniel T. Redford</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>3/5/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL T. Redford</b>   |   | 22e. ADDRESS<br><b>3001 S. HANOVER ST. Nt. MD.</b>  |   | 22f. ADDRESS<br><b>South BALTIMORE Gen. Hosp.</b>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   | 23b. DATE <b>3/8/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn A.A. Md.</b>  |   | 24. FUNERAL DIRECTOR <b>Balto., Md. 21225</b><br>NAME ADDRESS<br><b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1984</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |  |  |

BP \_\_\_\_\_

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

DATE: 1/18/84

TO: SAC, NEW YORK (100-111111)

FROM: SAC, NEW YORK (100-111111)



George J. Lince  
Rt. 1, Box 100  
Belto., Mo. 64001  
1/8/84  
Director, FBI  
Washington, D.C.  
MAR 1 1984

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |  |  |   |  | REG. NO.  |  |
|---|--|----------------------|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Linda D. Longshore</b>   |  |                      |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <b>3-14 1984</b>  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>4</b> YEAR <b>50</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>33</b> YRS.  |  | 7. DATE PRONOUNCED DEAD <b>3-14 1984</b>  |  | 2b. HOUR <b>8:51 a.m.</b>   |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital - DOA</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>  |  |                      |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2812 Harford Road 21218</b>                                |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Jessie</b> MIDDLE <b>J.</b> LAST <b>Wilson</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Clara</b> MIDDLE <b>G.</b> LAST <b>Toles</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>UNKNOWN</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>219-50-4596</b>  |  | 17. INFORMANT ADDRESS <b>Roosevelt Longshore 2812 Harford</b>                                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b><br><b>4254</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____   |  |                      |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                      |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Dennis F. Smyth</b>   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>   |  |  |  | MEDICAL EXAMINER  |  | DATE SIGNED <b>3-14-84</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                      |  | 23b. DATE <b>3/17/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE <b>Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Ave.</b>  |  |                      |  | 25a. DATE REC'D BY REGISTRAR <b>15 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>                                     |  |   |  |   |  |

RECEIVED  
JUL 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



14  
JUL 10 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 07152  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RED A L. LOPEZ                      |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 01 84 |   |  | 2b. HOUR<br>5 45 P.M.                                      |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 24, 1926  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Va.                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>City of Baltimore Hospitals |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Clerk   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Korvette's            |  |
| 13a. STATE<br>Maryland   |  |  |   | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>Baltimore                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                          |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>233-42-8324   |   | 17. INFORMANT<br>ADDRESS Balto. Md. 21225<br>William E. Jordan, Jr. 4200 Aurdrey Ave.,  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiac arrest

4589  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) hypotension

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2d

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

acidosis, cirrhosis, pneumonia

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/7, 19 84, to 3/1, 19 84, that (1) (we) last saw the deceased alive on 3/1, 19 84, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Michael S. Donnenberg, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/1/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL S. DONNENBERG  |  |  |  | 22e. ADDRESS<br>BALTO CITY HOSP  |  |  |  |

|  |  |                       |  |  |  |  |  |
|--|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>3/5/1984 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Edridge, Howard Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes  |  |                       |  | 25a. DATE REC'D BY REGISTRAR<br>MAR 5 1984                 |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 07153  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LORECK ROSE</b>  |  | FIRST MIDDLE LAST   |  | LORECK  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-31-84</b>  |  |   |  | 2b. HOUR<br><b>6:18 P.M.</b>                                     |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 XXX 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80 83</b> YRS.  |  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTIMORE</b> |  |   |  | 12a. HOUSEWIFE <input checked="" type="checkbox"/><br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                     |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. 1D #21215<br/>6503 Park Heights AVE.</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH KATZEN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHAEL GREENBERG</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217471261</b>   |  | 17. INFORMANT <b>MRS. DONNA POROVY 3107 NORTHBROOK</b>  |  |   |  |   |  |  |  |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4:00**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**24 HOURS**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/30/84</b> to <b>03/31/84</b> , that (I) (we) lost saw the deceased alive on <b>03/31/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R SEGAL</b>   |  |  |  | DEGREE<br><b>MBMB</b>  |  | 22c. DATE SIGNED<br><b>03/31/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R SEGAL</b>  |  |  |  | 22e. ADDRESS<br><b>60 SINAI HOSPITAL OF BALTIMORE</b>                          |  |  |  |

|  |  |                                  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>APR. 2, 1984</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAR SINAI</b> |  | 23d. CITY OR TOWN<br><b>BALTO.</b> STATE<br><b>MD</b>    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO. MD 21215</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 6 1984</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 07154   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Jesse Anthony Loudenslager   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-21-84  |  |
| 3. SEX<br>male   |  | 7b. HOUR<br>12 PM  |  |
| 4. RACE<br>white   |  | 7c. DATE OF DEATH MONTH DAY YEAR<br>3-21-84  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>6 12 1900   |  | 7d. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  | 7e. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours                                    |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>mechanic  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>automotive  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  |
| 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE<br>2101 Penrose Ave. 21223  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank Loudenslager  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Mchom   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>213 10 0059  |  |
| 17. INFORMANT<br>George E. Loudenslager  |  | ADDRESS<br>8385 Albacore Court Pasadena Md. 21122  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>4254<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary heart failure - shock</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary atherosclerosis</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Hours -<br>Years -   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/06 19 84, to 3/21 19 84, that (I) (we) last saw the deceased alive on 3/21 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |
| 22b. SIGNATURE<br>[Signature]  |  | DEGREE<br>MD, ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br>3/21/84  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTERS & ALBUQUERQUE MD  |  | 22e. ADDRESS<br>1540 U. Beth St Balto Md 21223   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial  |  | 23b. DATE<br>3/24/84   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>George J. Gonce   |  | 4001 Ritchie Hwy. Baltimore Md. 21225  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendall   |  |

1

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WAT 70 844

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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 0 3 5 5

|   |  |   |  |   |                            |
|---|--|---|--|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JUDY A. LOUDENSLAGER</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 26 84</b>   |   | 2b. HOUR<br><b>4:20 PM</b> |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>October 16, 1954</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>29</b>                     |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>R.N.</b>      |                            |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>  |  |   |  |   |                            |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Parkville</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>9 Windersal Lane - 21234</b>                            |                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Ernest Hagenbuch</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Concetta M. Calabrese</b>                   |   |                            |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-62-4907</b>  |  | 17. INFORMANT ADDRESS<br><b>George T. Loudenslager, Jr.-Same as #13e</b>          |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>diffuse hydrocytic lymphoma</b><br><b>2000</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs.</b> |  |   |  |   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |                            |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> , 19 <b>84</b> , to <b>3/26</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>3/26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                            |
| 22b. SIGNATURE<br><b>Robert J. Vissing, M.D.</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>3/26/84</b>  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT J. VISSING M.D.</b>  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-30-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                       |                            |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore, Maryland</b>   |  |   |  |   |                            |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  | 24b. ADDRESS<br><b>Towson, Md. 21204</b>  |  | 25. DATE REC'D BY REGISTRAR<br><b>MAR 29 1984</b>                                 |                            |
| 25a. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |   |  |   |                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

Rich Towson Funeral Home, Inc. Towson, Md. 21204  
 1050 York Rd.  
 Dulles Valley  
 Timonium, Baltimore, Maryland  
 2-30-64

No. 217-62-4907 George T. Jungsblader, Jr. - Same as #134  
 Ernest Frederick Conetta M. Calabrese  
 Maryland Baltimore Parkville x 9 Wintersal Lane - 21234  
 Hospital P.M. Hospital  
 U.S.A. White  
 October 16, 1934 29

NO COPY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07156

REG. NO.

84-7156

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Catherine Ludwig   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 18, 1984                  |   |  | 2b. HOUR<br>7:00P M   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 5, 1891  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bel Air Convalesarium |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tailoring   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>-   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>Balto, Md.<br>6410 Sefton Ave, 21214   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>August Runge  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Kraft  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>-  |   | 17. INFORMANT<br>ADDRESS<br>Balto, Md.<br>Grace Slechter, 6410 Sefton Ave, 21214 |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA VAGINA WITH<br>1840<br>DUE TO, OR AS A CONSEQUENCE OF METASTASIS<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/><br>OR CONTRIBUTING: <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(ST HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (not) see the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Luis E. Rivera, MD PA   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/20/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS<br>6116 Belair Rd, Balto, Md.                             |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3/21/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem.                              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHIMUNEK FUNERAL HOME, 3331 Brehms La,   |  |  | ADDRESS<br>2121323 1984  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with you for the death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07157

1 - FOR  
STATE  
REGISTRAR

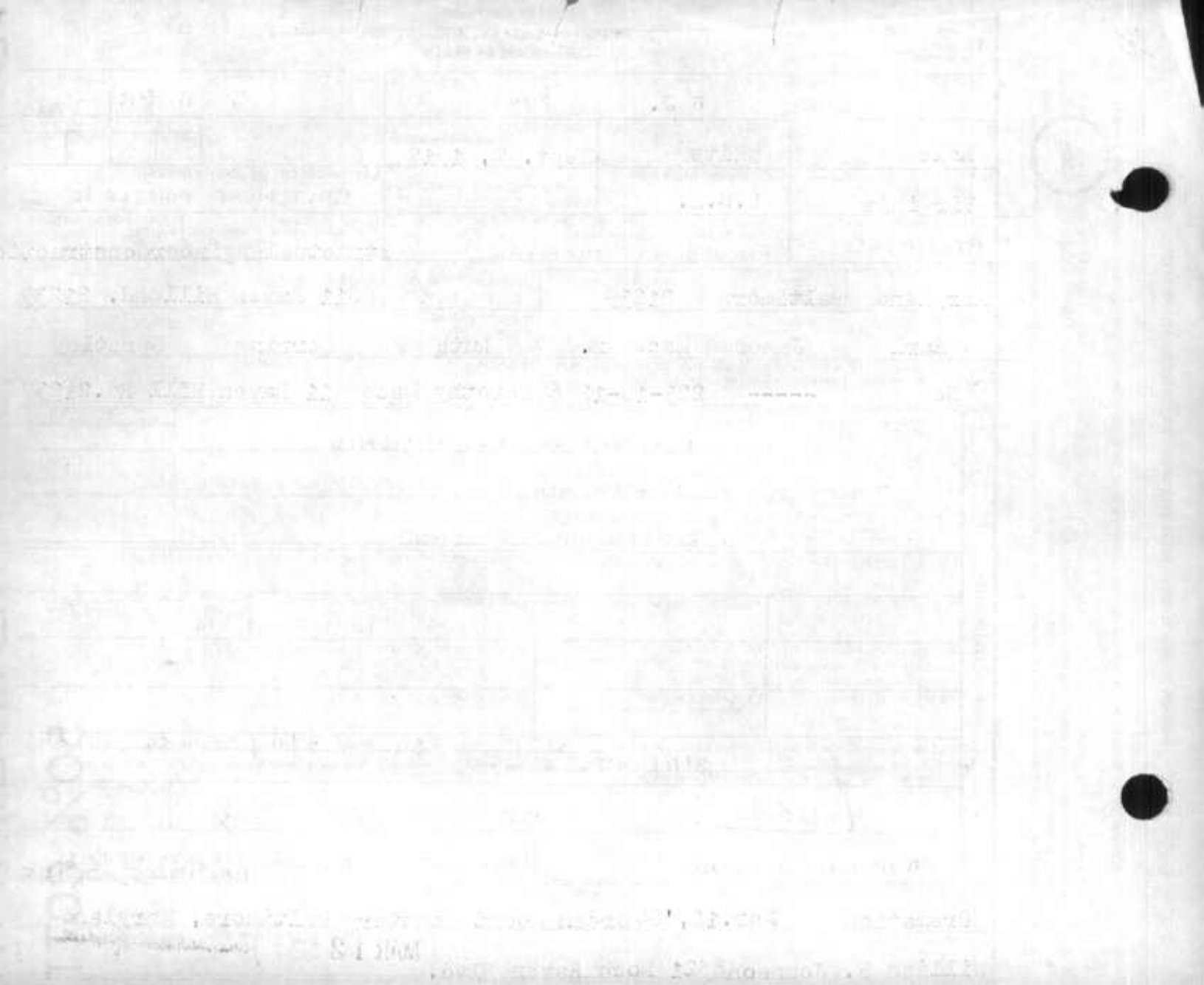
REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EARL J. MACE  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>3 11 84 |   |  | 2b. HOUR<br>3:26 PM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 7, 1917   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, MARYLAND MD   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Structural Engineer Construction                       |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>21239  |  | 13d. STREET ADDRESS<br>6611 Raven Hill Rd. 21239   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Earl James Mace Sr.   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth Derrington Spratley   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  |   | 17. INFORMANT<br>ADDRESS<br>Dorothy Mace 6611 Raven Hill Rd. 21239  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PNEUMONIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CARCINOMA OF LUNG</u> |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)</u>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>84</u> , to <u>3/11</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Padma S. Udupi</u>   |  |   |   | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PADMAJA S. UDAPI   |  |   |   | 22e. ADDRESS<br>PROVIDENT HOSPITAL, 2600 LIBERTY HEIGHTS BALTIMORE, MD 21215  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>Mar. 12, '84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cemetery Baltimore, Maryland  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |  |   |   | 24b. ADDRESS<br>8521 Loch Raven Blvd.   |  |  |  |

BP

MAR 12 1984

25a. DATE REC'D BY REGISTRAR  
25b. REGISTRAR'S SIGNATURE  
John A. Anderson



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO. 07158   |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  | 2b. DATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LESLIE MACKLIN</b>  |  |   |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3 10 1984</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>BLACK</b>                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 10 18 66</b>  |  | 6. AGE (IN YEARS) LAST BIRTHDAY YRS.<br><b>66</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br><b>3 10 1984</b>   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAR.</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                           |  |  |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |   |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hosp.</b>                  |  |  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 15. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |  |  |  |  |
| 17a. STATE<br><b>MD.</b>   |  | 17b. COUNTY<br><b>BALTO.</b>              |  | 17c. CITY OR TOWN<br><b>BALTO.</b>  |  | 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 17e. STREET ADDRESS<br><b>804 CHAUCEY AVE.</b>                                   |  | 17f. CHAUNCEY AVE.   |  |
| 18. FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-8212</b>  |  |  |  | 17. INFORMANT ADDRESS<br><b>Walzetter FISHER 804 CHAUCEY AVE.</b>                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>  |  |   |  | M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>3-11-84</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   |  | 23b. DATE<br><b>3/ 16/ 84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND NAT'L MEM</b>                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>LAUREL Md.</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                       |  |  |  |

ADDITIONAL INFORMATION

FREE

WIND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

DHWB - 16 50M 4/82  
(VNA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |  |
|--|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>First</b> Eunice <b>Middle</b> Lee <b>Last</b> MacLeod  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br><b>03 16 84 8 pm</b>   |  |   |  |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 10 12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balt City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP. OF BALTIMORE</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>Howard</b>   |  | 13c. CITY OR TOWN <b>Sykesville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>R.</b> LAST <b>Boyer</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Lindsay</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |  |
| 16b. SOCIAL SECURITY NO. <b>217-50-0703</b>  |  | 17. INFORMANT ADDRESS <b>Nelson J. MacLeod (same as above)</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Lung Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/16/84</b> to <b>3/16/84</b> , that (we) last saw the deceased alive on <b>3/16/84</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE <b>Marc Paul MD</b> DEGREE <b>MD</b>  |  |   |  | 22c. DATE SIGNED <b>3/16/84</b>   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC PAUL MD</b>  |  |   |  | 22e. ADDRESS <b>SINAI HOSP. OF BALTIMORE</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>3-19-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |
| 24. FUNERAL DIRECTOR <b>Thomas D. Fletcher &amp; Son</b><br><b>254 East Main Street</b><br><b>Westminster, Md. 21157</b>   |  |   |  | 25. DATE REC'D BY REGISTRAR <b>MAR 21 1984</b>  |  |   |  |  |
| 26. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>  |  |   |  |   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07160

|  |  |   |  |
|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ETHEL L. MACRAE   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-26-84   |  |
| 3. SEX<br>Female   |  | 2b. HOUR<br>8 P M   |  |
| 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 1, 1901  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  |
| 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br>3309 Glenmore Ave. 21214   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Edward Forsyth  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amanda/ Amanda Snyder  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213-06-3708   |  |
| 17. INFORMANT<br>ADDRESS<br>Maude Bentley 3309 Glenmore Ave. 21214   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured diverticulum with abscess</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic lymphatic leukemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>2041<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3/12/84.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><u>History of urinary tract infection and anemia.</u>   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>March 26, 1984</u> to <u>March 26, 1984</u> , that (2) (we) lost saw the deceased alive on <u>March 26, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br>S. Luke  |  | 22c. DATE SIGNED<br>March 26, 1984  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Luke   |  | 22e. ADDRESS<br>201 E University Pkwy Baltimore MD.   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/27/84  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1984  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rodgers   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07161

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George A. Maddox</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 26 84</b>   |  | 2b. HOUR<br><b>145 AM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 15 13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY of Baltimore</b> MD.                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>General Electric Co</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>412 Gittings St., Baltimore 21230</b>           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Maddox</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle Croke</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-5025</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Evelyn Maddox, Same as above</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD &amp; ASCVD</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Metastatic Disease</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 24, 1984</b> to <b>March 26, 1984</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Juanas</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>March 26, 1984</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDRINCA JUANAS-VARELA</b>   |  | 22e. ADDRESS<br><b>3001 S. Anover street. Balto. Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>March 28, 1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 29 1984</b>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Robert MAGID</b>  |  |  |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>84</b>  |  |   |  |
| 3. SEX <b>male</b>  |  |  |  | 2b. HOUR <b>12 AM</b>  |  |   |  |
| 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH <b>March</b> DAY <b>30</b> YEAR <b>26</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.   |  | 7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-Employ.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>AnneArundel</b>   |  | 13c. CITY OR TOWN <b>GlenBurnie</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <b>Morris</b> MIDDLE <b></b> LAST <b>D</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Rena</b> MIDDLE <b></b> LAST <b>Kolodny</b>  |  | 16. STREET ADDRESS <b>8103 Stonehaven Drive</b>  |  | 17. ZIP CODE <b>21061</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO. <b>W.W. II 220-14-2447</b>  |  | 17. INFORMANT <b>Mr. Earle Magid (Brother)</b>   |  | 18. ADDRESS <b>Coble Stone Ct., Baltimore, Md. 21215</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5759 IMMEDIATE CAUSE (a) CAD Diapylmonary Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>respiratory distress</b><br>(c) <b>empyema, Diabetes mellitus, cirrhosis, Sepsis</b> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>2/24</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholecystectomy, tracheostomy</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>3/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Melvin J. Duckert, MD</b>  |  | 22e. ADDRESS <b>Mercy Hospital</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>13 MAR '84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oheb Shalom Mem. Pk.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>J. Shannon</b>   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |
| HEBREW MEMORIAL FUNERAL HOME, PIKESVILLE, MD.   |  |  |  |  |  |   |  |

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13 MAR '84 Chas Shalom Mem. Dr. Baltimore Md.

Final

COPIES



YES W.V. II Mr. Earle Mard (brother) 21215

Morris Mard

0

1000 Stone Ct., Baltimore, Md.  
Koloony

X 8103 Stonehaven Drive

Baltimore

Self-Employ. Butcher  
21051

Baltimore, MD U.S.A.

MARCH

Robert "Mard" MARD



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR AKA Sr. Mary Concepta   |  |  |  |  | CERTIFICATE OF DEATH                         |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 7a. DATE OF DEATH MONTH DAY YEAR             |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Sister Concepta Maguire  |  |  |  |  | 7a. DATE OF DEATH MONTH DAY YEAR<br>03/19/84 |   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 29 35  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.  |  | 7b. HOUR<br>11:38A   |  |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ireland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Ireland  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse & Rel. Nun Church        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>New York   |  | 13b. COUNTY<br>✓   |  | 13c. CITY OR TOWN<br>Castleton   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>Mt. St. Josephs Provincilaite 99919 12033  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Patrick Maguire   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Whelan  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |  |  | 16b. SOCIAL SECURITY NO.<br>063-50-9661  |  | 17. INFORMANT ADDRESS<br>8 Dudley Hts. N.Y. 12210<br>Lasak & Gigliotti F. H., Inc.              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypotension</u><br><u>5728</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Liver failure</u> |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hours</u><br><u>3/18</u><br><u>many weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Budd Chauri Syndrome</u>  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>2/24/84</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Budd Chauri syndrome</u>  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>84</u> , to <u>March 19</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March 19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Elena Strahelmer</u>  |  |  |  | DEGREE<br><u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>3/19/84</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ER Strahelmer</u>  |  |  |  | 22e. ADDRESS<br><u>Johns Hopkins</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/23/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Resurrection Cemetery</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Castleton Rennsler N.Y.                              |  | 23e. DATE REC'D. BY REGISTRAR  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |  | 24b. ADDRESS<br>21229  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 21 1984  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Elena Strahelmer</u>  |  |

MEDICAL CERTIFICATION

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Blank lined paper with faint horizontal lines and two punch holes on the right side.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07164

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Nicholas</b><br><del>MAISTROS</del>           |  | MIDDLE<br><b>G.</b>   |  | LAST<br><b>MAISTROS</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 5 84</b>                               |  | 2b. HOUR<br><b>12:32 AM</b>                                      |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 23, 1902</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore Maryland</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RET.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Laundry</b>              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Perry Hall</b>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>9217 Cornflower Rd 21236</b>               |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George C. Maistros</b>                        |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Angela Kapous</b>                              |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>      |  | 16b. SOCIAL SECURITY NO.<br><b>214-34-2847</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary Maistros, 9217 Cornflower Rd. 21236</b>   |   |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary Arrest**4100  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Coronary Artery Disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 3</b> , 19 <b>84</b> , to <b>March 5</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>March 3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert E. Fisher M.D.</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/5/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert E. Fisher M.D.</b>   |  | 22e. ADDRESS<br><b>Baltimore City Hospital<br/>4940 Eastern Ave., Baltimore, MD 21204</b> |  |   |  |  |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>3/8/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orth. Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck, Inc</b>   |  |                            |  | ADDRESS<br><b>5305 Harford Rd.</b>                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>                       |  |
|  |  |                            |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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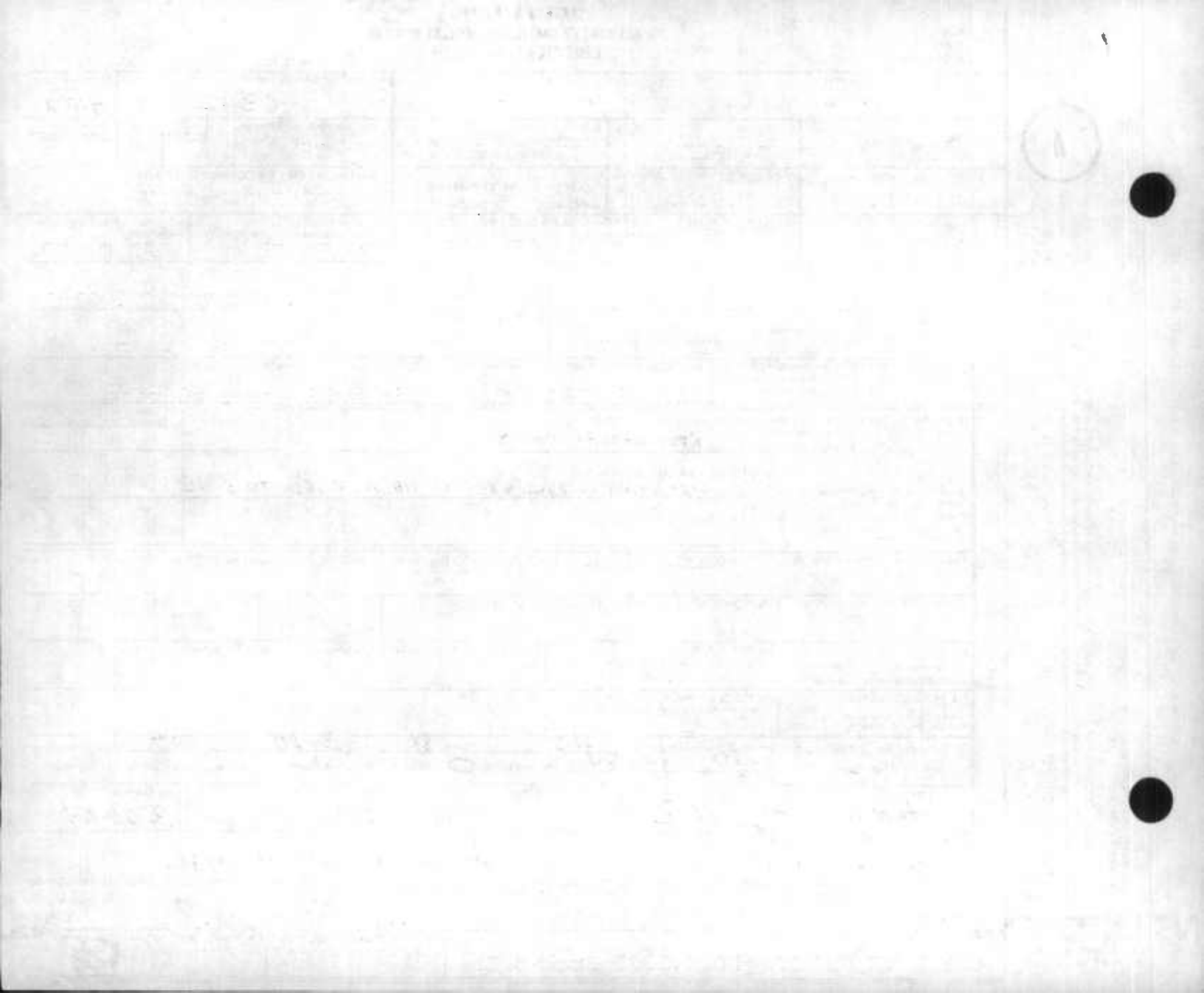
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                                     |   | REG. NO.           |  |  |
|--|--|--|-------------------------------------|---|--------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |   | 2a. DATE OF DEATH  |  |  |
|  |  |  | PETER - MALINOWSKI                  |   | 03-20-84 4:00 A.M. |  |  |
| 3. SEX   |  | 4. RACE  |                                     | 5. DATE OF BIRTH  |                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MALE   |  | CAUCASIAN  |                                     | APRIL 26 1907   |                    | 76 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |
| MD.  |  | U.S.A.   |                                     |   |                    | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                      |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                    | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |
| BALTIMORE  |  | BALTIMORE CITY HOSPITAL  |                                     | CHAUFFEUR   |                    | BALTO. CO.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |                                     | 13c. INSIDE CITY LIMITS?  |                    | 13d. STREET ADDRESS  |  |
| MD.  |  | BALTIMORE  |                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                    | 444 N. CLINTON ST. 21224   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                    | 16b. SOCIAL SECURITY NO.   |  |
| STANLEY  |  | MARY WROBLEWSKI  |                                     | YES   |                    | 215-05-5594  |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) |                                     | 19. DATE OF OPERATION   |                    | 20a. AUTOPSY?  |  |
| Helen Malinowski, same address   |  | RESPIRATORY ARREST   |                                     | 1850  |                    | YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) PROSTATIC CANCER C METASTASES TO BONE  |                                     |   |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?         |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                                     |   |                    | YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                                     |   |                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                    | 21d. INJURY OCCURRED   |  |
|  |  |  |                                     |   |                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
| 21f. LOCATION<br>STREET  |  | 21g. CITY OR TOWN  |                                     | 21h. COUNTY   |                    | 21i. STATE   |  |
|  |  |  |                                     |   |                    |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15 19 84, to 3-20 19 84, that (I) (we) last saw the deceased alive on 3-20 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |  |                                     |   |                    |  |  |
| 22a. SIGNATURE   |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |                                     | 22c. ADDRESS  |                    | 22d. DATE SIGNED   |  |
| Andrew Yang M.D.   |  | ANDREW YANG  |                                     | BALTIMORE CITY HOSPITAL   |                    | 3-20-84  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |                                     | 23c. NAME OF CEMETERY OR CREMATORY  |                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                             |  |
| Burial   |  | 3/23/84  |                                     | Holy Rosary Cem.  |                    | Balto, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |                                     | 25b. REGISTRAR'S SIGNATURE  |                    | 25c. DATE OF DEATH   |  |
| SCHIMUNEK FUNERAL HOME, 3331 Brehms La,  |  | 2/23/84  |                                     | [Signature]   |                    | 03-20-84   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed - within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George H. Manning, Sr.   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 3 1984 |  |  | 2b. HOUR<br>10:10PM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 13, 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel Worker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Co.   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>--   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>Balto, Md.<br>5715 Daybreak Terr, 21206   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Andrew Manning  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gertrude Patterson  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>217-05-7720  |  | 17. INFORMANT ADDRESS<br>George H. Manning, Jr, 5715 Daybreak Terr.   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE TO<br>4100 Pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br>status post Myocardial Infarction   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from March 1, 1984, to March 3, 1984, that we lost the deceased alive on March 3, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true, did not view the body after death.)   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>J. Mannisi   |  |   | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/3/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Mannisi  |  |   | 22e. ADDRESS<br>M.D. Church Hospital 100 n. Broadway Baltimore Md.     |   |  | 21231  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/7/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHIMUNEK FUNERAL HOME, 3331 Brehms La, 21227  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>W. Anderson-Rendell  |  |  |  |

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THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07167

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BLANDINE R. MARKS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 29 84</b>                  |   | 2b. HOUR<br><b>10:40</b><br>A M   |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 6 04</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b><br>YRS.                           |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Home</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hair dresser</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>      |  |  |
| 13a. STATE<br><b>Md.</b>   |  |   |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Thomas Robinson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret L. McEntee</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>066-01-2409</b>  |   | 17. INFORMANT<br><b>Ms. Catherine C. Spurrier W. Friendship, Md.</b>           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4920 IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA, SEVERE -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 YRS.</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>A.S.C.V.D. WITH HEART FAILURE -</b>  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 16 1969</b> , to <b>MARCH 29 1984</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 21 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Carlton L. Sexton</b><br>DEGREE<br><b>M.D.</b>  |  |   |  |   |   | 22c. DATE SIGNED<br><b>3-30-84</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carlton L. Sexton, M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>Balto. Life Bldg., 901 N. Howard, Balto. 21201</b>          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  |   | 23b. DATE<br><b>3/29/84</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 4 1984</b>                             |  |  |  |
| ADDRESS<br><b>Balto., Md.</b>  |  |   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                             |  |  |  |

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90  
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record must be made available to the coroner.

BP



100% COTTON

CHIEFMAN



W. S. V. D. NEW HAVEN, CT.

18 PL H. 18 PS - 21 18T

18 05-2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |                          |  |  |   |  |                                   |                        |  |  |
|---|--|--|--------------------------|--|--|---|--|-----------------------------------|------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST        |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  |                                   |                        | 2b. HOUR                                     |  |
| ANNA  |  |  | MARKWORDT                |  |  | MARCH 31, 1984  |  |                                   |                        | 7:10 PM                                      |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                   |                        | IF UNDER 24 HRS.                             |  |
| FEMALE  |  | WHITE  |                          | 9 23 1904  |  | 79 YRS.   |  | MONTHS DAYS                       |                        | HOURS MIN.                                   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |                        |  |  |
| MARYLAND  |  | U. S. A.   |                          |  |  | Baltimore City MD.  |  |                                   |                        |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |  |
| Baltimore   |  | Church Home & Hospital   |                          |  |  | HOMEMAKER   |  |                                   |                        |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. CITY OR TOWN        |  |  | 13c. INSIDE CITY LIMITS?  |  |                                   | 13d. STREET ADDRESS    |  |  |
| MARYLAND  |  |  | BALTIMORE                |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   | 10 N. MILTON AVE 21234 |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |  |   |  |                                   |                        |  |  |
| MARTIN GOSSMAN  |  |  | UNKNOWN                  |  |  |   |  |                                   |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO. |  |  | 17. INFORMANT ADDRESS   |  |                                   |                        |  |  |
| NO  |  |  |                          |  |  | LOUISE DOMZAKSKI 10 N. MILTON AVE.                                  |  |                                   |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |  |   |  |                                   |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 8809  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| (b) <u>PULMONARY EMBOLISM</u>   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| (c)   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| FRACTURE RIGHT HIP  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 19a. DATE OF OPERATION MARCH 1, 1984  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE HIP   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| MARCH 31, 1984 FEEDING GASTROSTOMY  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 2 27 1984   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| Fell down steps ACCIDENT  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 21d. INJURY OCCURRED  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| home  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 10 N. Milton Ave 4 Balto. Md.   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>MARCH FEBRUARY 27</u> to <u>MARCH 31</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 31</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 22b. SIGNATURE  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 22c. DATE SIGNED  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| BXXXXXX MURARI BYPURIA  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 22e. ADDRESS  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 100 NORTH BROADWAY 21231 CHURCH HOSPITAL  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| BURIAL  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 23b. DATE   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 4/3/84  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| MORELAND  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| BALTIMORE MD.   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 24. FUNERAL DIRECTOR  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| RAYMOND L. KACZOROWSKI 2525 FLEET ST.   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 25a. DATE REC'D. BY REGISTRAR   |  |  |                          |  |  |   |  |                                   |                        |  |  |
| APR 4 1984  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |                          |  |  |   |  |                                   |                        |  |  |
| [Signature]   |  |  |                          |  |  |   |  |                                   |                        |  |  |

BP

20% COTTON

CHILMARK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 07169  
07169

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>ISA M. HENRY MARSHALL</u>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>3/8/84</u> |  |  | 2b. HOUR<br><u>4:45 A</u>   |  |  |  |
| 3. SEX<br><u>FEMALE</u>   |  | 4. RACE<br><u>BLACK</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>5 16 05</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>78</u> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>BALTIMORE MD</u>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY MD.</u>                            |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>1649 S. SMALLWOOD ST</u> |  |  |  | 14. USUAL OCCUPATION<br>(TIME OF WORK FOR MOST OF WORKING LIFE)<br><u>DOMESTIC PRT Family</u> |  | 15. KIND OF BUSINESS OR INDUSTRY                                   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <u>MD</u> |  | 16b. COUNTY <u>BALTIMORE</u>   |  | 16c. CITY OR TOWN <u>BALTIMORE</u>   |  | 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 16e. STREET ADDRESS / ZIP CODE<br><u>1649 SMALLWOOD ST 21216</u>   |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>JOHN B. GARNETT</u>  |  |  |  | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>MARION MARSHALL</u>  |  |   |  |  |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u>                                       |  |  |  | 20. SOCIAL SECURITY NO.<br><u>312-26-3142-A</u>  |  | 21. INFORMANT<br>ADDRESS<br><u>LILLIAN CROSS 1649 S. SMALLWOOD</u>                            |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line 1a (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Squamous Cell Lung Cancer

1629  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <u>83</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>83</u> , to <u>March 1</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>March 1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>P. Kenito</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>3/9/84</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>P. Kenito</u>   |  | 22e. ADDRESS<br><u>730 Ashburton St</u>                                |  |  |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>              |  | 23b. DATE<br><u>3/12/84</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT AUBURN</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE MD</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Marshall &amp; Hayes 6385 Gilman St</u> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 16 1984</u>    |  | 25b. REGISTRAR'S SIGNATURE<br><u>W. Davidson-Randall</u>          |  |

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100%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07170

REG. NO.

|   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Theresa M. Marshall</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 27, 1984</b>          |  |   | 2b. HOUR MIN<br><b>11:30 AM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 30, 1896</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>87</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Home, Balto. Md.</b> |  |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland Baltimore Baltimore</b>  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 18. STREET ADDRESS / ZIP CODE<br><b>1507 Kirkwood Rd. Balto. Md. 21207</b>   |   |  |  |   |  |
| 19. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank S. Seidl</b>  |  |   |  | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna ----- Dauer</b>  |   |  |  |   |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 22. SOCIAL SECURITY NO.<br><b>213-74-0852</b>   |  | 23. INFORMANT ADDRESS<br><b>Francis X. Marshall, 229 Homewood Rd. Linthicum, Md. 21090</b>   |   |  |  |   |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539 Malignancy in Colon</b><br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |  |   |  |  |   |  |
| 25. DATE OF OPERATION   |  |   | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 34. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1-26 84 3-27 84</b>  |  |   |  |
| 35. I certify that (I) (this hospital) (name of decedent) from above the deceased alive on (date) 1-26-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.   |  |   |  |  |   |  |  |   |  |
| 36. SIGNATURE OF PHYSICIAN<br><b>William G. Helfrich M.D.</b>   |  |   |  |  |   | 37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 38. DATE SIGNED<br><b>3-28-84</b>   |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 40. ADDRESS<br><b>5006 Roland Ave. Balto. Md.</b>                  |  |   |  |  |   |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 42. DATE<br><b>Mar. 31, 1984</b>                                   |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b> |  | 44. LOCATION CITY OR TOWN COUNTY<br><b>Baltimore, Maryland</b> |   |  |
| 45. FUNERAL DIRECTOR<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   |  |  |   | 46. DATE REC'D. BY REGISTRAR<br><b>MAR 29 1984</b>   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07171

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                                |  |   |   |  |  |
|--|--|---|--|---|--------------------------------|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVID LEE MARTIN  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3.3.84                    |   |                                | 2b. HOUR<br>130 AM   |   |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 19 49  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>34 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD.                       |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1602 S. Hanover Street |  |   |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tree Surgeon |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tree Expert                |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Shirley R. Martin  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Opal C. Mullins |   |                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES      |   |   | 16b. SOCIAL SECURITY NO.<br>1968-1971 213 522410 |  |
| 17. INFORMANT<br>ADDRESS<br>Frances R. Martin Same as 13c  |  |   |  |   |                                |  |   |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) UREMIA

1539  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ADENOCARCINOMA of colon &amp; liver metastasis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
6 months

4 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-16, 1983, to 3-3, 1984, that (I) (we) lost<br>saw the deceased alive on 3-2-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Dorothy Snow MD  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/5/84   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DOROTHY SNOW  |  | 22e. ADDRESS<br>VETERAN'S HOSPITAL<br>8900 Loch Raven Blvd, BALTO. MD 21218  |  |  |  |   |  |

|   |  |                     |  |  |  |   |  |
|---|--|---------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial              |  | 23b. DATE<br>3/6/84 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Veterans Cem                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville A.A. Md |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy, Balto, Md |  |                     |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAR 7 1984 Julia Davidson-Rodell |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IVF-EGF

Self-Analysis

2502

Items 18-22a 5/7/84 mtb F#591

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

7 1 7 2

1- STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                |  |  |   |  |   |  |   |  |
|---|----------------|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EDWIN Meek MARTIN, JR.  |                |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>3 22 1984   |  |   |  | 2b. HOUR<br>AM PM<br>6:10 am  |  |
| 1. SEX<br>male  | 4. RACE<br>Col | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3-19-1981  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>2 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 22 1984   |  | 2d. HOUR<br>AM PM<br>6:10 am  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Baby                           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland  |                | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>21215<br>5018 Denmore Ave                                    |  |
| 14. FATHER'S NAME<br>Edwin Meek   |                | 14b. SOCIAL SECURITY NO.<br>None   |  | 15. MOTHER'S MAIDEN NAME<br>Joyce Feimeter  |  | 16. INFORMANT<br>Mrs. Joyce Martin 5018 Denmore Ave 21215                                       |  |   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |                | 17b. SOCIAL SECURITY NO.<br>None   |  | 17c. INFORMANT<br>Mrs. Joyce Martin 5018 Denmore Ave 21215  |  | 17d. ADDRESS<br>21215<br>5018 Denmore Ave   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertrophic cardiomyopathy complicated by</u><br><u>4254</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <u>bronchitis and bronchiolitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>      |                |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.  |                | TITLE (SPECIFY)<br>Assistant M.D.  |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED 3-22-84   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |                | ADDRESS 111 Penn St., Balto., Md. 21201  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(LIFT)   |                | 23b. DATE<br>3-28-84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Waterloo How Co. Md.                              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |                | ADDRESS<br>Joseph L. Russ 2222 W. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1984  |  | 25b. REGISTRAR'S SIGNATURE<br>K. Davidson-Rendall                                   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

WIA 00007

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MAR 22 1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07173

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                                   |
|---|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)       |  | FIRST Iris MIDDLE L. LAST Martin   | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  | 2b. HOUR                          |
| DIES                                      |  | MARTIN   | 3 24 84   |  | 11 30 AM                          |
| 3. SEX                                    | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))  |                                   |
| Female                                    | White  | 2 26 1905  |   | 79 YRS.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |
| England                                   | Great Britian  |  |   | Baltimore City MD.   |                                   |
| 10. CITY OR TOWN OF DEATH                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore                                 | Baltimore City Hospital  |  | Housewife   |  |                                   |
| 13a. STATE                                |  | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS               |
| Maryland                                  | Baltimore  | Dundalk  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1819 Portship Road 21222          |
| 14. FATHER'S NAME FIRST MIDDLE LAST       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |                                   |
| William Heden                             |  | Florence Prout   |   | No   |                                   |
| 17. INFORMANT                             |  | 18. SOCIAL SECURITY NO.  |   | 19. ADDRESS  |                                   |
| Gordon E. Martin                          |  | 153-10-3843  |   | 1819 Portship Road Balto. MD 21222   |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Failure  
7991  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Unknown  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |
|  | P.M. 19   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |
|  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 29</u> , 19 <u>84</u> , to <u>March 29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>March 29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE   |   | DEGREE  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |
| <u>MD</u>  |   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |  |  |
| S. E. VANCE  |   |   |  |  |  |

|   |           |                                    |   |
|---|-----------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial                                    | 3/27/84   | Oak Lawn Cemetery                  | Baltimore Maryland                      |
| 24 FUNERAL DIRECTOR NAME                  |           | 25a. DATE REC'D. BY REGISTRAR      |   |
| Duda-Ruck, Inc.                           |           | MAR 27 1984                        |   |
| 7922 Wise Avenue, Dundalk, MD 21222       |           | 25b. REGISTRAR'S SIGNATURE         |   |
|   |           | <u>G. E. Martin</u>                |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the body retained for 24 hours.

APR 11 1934





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the 12 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |                          |  |        |                 |      | REG. NO.   |       |                                   |      |          |
|---|--|--|--|--|--------------------------|--|--------|-----------------|------|--|-------|-----------------------------------|------|----------|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 26. DATE OF DEATH        |  |        |                 |      |  |       |                                   |      |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | FIRST                    |  | MIDDLE |                 | LAST |  | MONTH | DAY                               | YEAR | 26. HOUR |
| Lettie C. Martin  |  |  |  |  |                          |  |        |                 |      |  | 3     | 18                                | 84   | 1.10 AM  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)                                |        | IF UNDER 1 YEAR |      | IF UNDER 24 HRS  |       |                                   |      |          |
| Female  |  | Black  |  | 9 28 16  |                          | 68   |        | MONTHS          |      | DAYS   |       | HOURS MIN.                        |      |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |        |                 |      |  |       |                                   |      |          |
| S.C. Carolina   |  | U.S.   |  |  |                          | Baltimore City MD.   |        |                 |      |  |       |                                   |      |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          |  |        |                 |      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |       | 12b. KIND OF BUSINESS OR INDUSTRY |      |          |
| Baltimore   |  | Bon Secours Hospital   |  |  |                          |  |        |                 |      | Retired  |       |                                   |      |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13a. STATE               |  |        |                 |      | 13b. COUNTY  |       |                                   |      |          |
| 13a. STATE  |  |  |  |  | 13b. COUNTY              |  |        |                 |      | 13c. CITY OR TOWN  |       |                                   |      |          |
| MD.   |  |  |  |  | Baltimore                |  |        |                 |      | Baltimore  |       |                                   |      |          |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |        |                 |      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |                                   |      |          |
| Mose Cherry   |  |  |  |  | Emma Boyd                |  |        |                 |      | 13e. STREET ADDRESS / ZIP CODE   |       |                                   |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |  |        |                 |      | 17. INFORMANT ADDRESS  |       |                                   |      |          |
|   |  |  |  |  | 218-18-5313              |  |        |                 |      | Mrs Sallie Hatter 161-E. 33rd St. 21218  |       |                                   |      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). 5070   |  |  |  |  |                          |  |        |                 |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |       |                                   |      |          |
| DUE TO, OR AS A CONSEQUENCE OF (b). septic shock  |  |  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c). Bilateral aspiration pneumonia   |  |  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. diabetic gangrenous R. foot & decubitus ulcer of hip.  |  |  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |        |                 |      |  |       |                                   |      |          |
| 3/13/84   |  | Gangrene of foot & decubitus ulcer R. hip  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |        |                 |      |  |       |                                   |      |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                          |  |        |                 |      |  |       |                                   |      |          |
|   |  | HOUR AM. MONTH DAY YEAR  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
|   |  | P.M.   |  | 19   |                          |  |        |                 |      |  |       |                                   |      |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |                          | CITY OR TOWN   |        | COUNTY          |      | STATE  |       |                                   |      |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| 22a. I certify that (1) this hospital attended the deceased from 3/13/84 to 3/18/84 that (1) (we) last saw the deceased alive on 3/17/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death |  |  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |                          | 22c. DATE SIGNED   |        |                 |      |  |       |                                   |      |          |
| G.Y. Apostolides  |  |  |  |  |                          | 3/18/84  |        |                 |      |  |       |                                   |      |          |
| 22d. PHYSICIAN'S NAME (PRINT)   |  | 22e. ADDRESS   |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| G.Y. APOSTOLIDES  |  |  |  |  |                          |  |        |                 |      |  |       |                                   |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION (CITY OR TOWN)                                   |        | COUNTY          |      | STATE  |       |                                   |      |          |
| Burial  |  | 3 2384   |  | Ardenwood  |                          | Baltimore  |        | Baltimore       |      | MD   |       |                                   |      |          |
| 24. FUNERAL DIRECTOR  |  | 24b. ADDRESS   |  | 25a. DATE REC'D BY REGISTRAR   |                          | 25b. REGISTRAR'S SIGNATURE                                     |        |                 |      |  |       |                                   |      |          |
| William L. McKim  |  | 3207 W. 7th St   |  | MAR 18 1984  |                          | [Signature]  |        |                 |      |  |       |                                   |      |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | 07175                      |  |
|--|--|--|---|---|----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO.                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CYNTHIA MASON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 27 84</b> |   | 2b. HOUR<br><b>12:26pm</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 13, 1951</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>32</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of Md.</b>   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Granville E. Simms</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Alexander</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4517 Fairfax Rd. Baltimore, Maryland 21216</b>   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-58-0318</b>   |   | 17. INFORMANT ADDRESS<br><b>Charles L. Mason Jr. Baltimore, Md. 21216</b>   |                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1350</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>End Stage Sarcoidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 26</b> , 19 <b>84</b> , to <b>March 27</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>March 27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |   |                            |  |
| 22b. SIGNATURE<br><b>Lester L. Lewis Jr.</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>3/27/84</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lester L. Lewis Jr.</b>  |  | 22e. ADDRESS<br><b>2600 Liberty Heights Ave.</b>   |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/3/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans Cemetery</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1984</b>   |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>   |  |  |   |   |                            |  |



Female  
Black  
19. 1901 32  
U. S. A.  
Baltimore City  
President Hospital  
Secretary  
State of Md.  
Baltimore, Maryland 21216  
E. Grubbe  
Jimmie  
Mattie  
Alexander  
317 Fairfax Road  
Baltimore, Md. 21216  
No. 31-45-0316 Charles L. Mason Jr. Baltimore, Md. 21216

Constitutional Party  
and State Party

31-45-0316  
Veterans Cemetery  
Garrison Forest  
Baltimore, Md.  
Witter & Sons Funeral Home Inc.  
2501 Gwynns Falls Pk. Baltimore, Md. 21216  
Baltimore, Md. 21216  
Baltimore, Md. 21216

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07176

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |                                   |
|--|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAMONT THOMAS MASSEY</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>13</b> YEAR <b>84</b>                       |  | 2b. HOUR <b>2:20</b> M <b>M</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>14</b> YEAR <b>52</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b> YRS.                                    |                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Balto. Md</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                         |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Balto. City</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Md</b>  |   |   | 13b. COUNTY<br><b>Balto</b>  | 13c. CITY OR TOWN<br><b>Balto</b>  |                                   |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>H.</b> LAST <b>Massey</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bernice</b> MIDDLE <b>NIXON</b> LAST <b>NIXON</b> |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>929 Ellicott Dr. - Bernice Nixon</b>                             |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b><br><b>7070</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>decubitus ulcers / massive pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 30</b> , 19 <b>83</b> , to <b>MAR 13</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>MAR 13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |                                   |
| 22b. SIGNATURE<br><b>E. G. Moseley</b>   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/14/84</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. G. Moseley</b>  |   | 22e. ADDRESS<br><b>Deaton Med Center</b>  |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |   | 23b. DATE<br><b>3-17-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. PK.</b>                        |                                   |
| 24. FUNERAL DIRECTOR<br>NAME <b>LeRoy O. Dyett</b> ADDRESS <b>4600 Liberty Hgts. Ave.</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Balto. Md.</b> COUNTY STATE  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>                                  |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |   |   |  |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Margaret Mathews</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>3 27 84</i>   |  |  |  |
| 3. SEX <i>F</i>  |  | 4. RACE <i>B</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>3 11 19</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>US</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hosp</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SEAMRESS</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <i>MARYLAND</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <i>BALTIMORE</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <i>UNKNOWN</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <i>CORA JONES</i>  |  | 13e. STREET ADDRESS <i>2121 WINDSOR GARDEN LANE 21207</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><i>LEON JONES 9820 CERRIGAN CT. 21133</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>4360</i> IMMEDIATE CAUSE (a) <i>Cerebrovascular accident.</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)<br><i>Congestive heart failure. Urinary tract infection.</i>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-19</i> , 19 <i>84</i> , to <i>3-27</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>3-27</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Mathews</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>3/27/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A. Mathew</i>  |  |  |  | 22e. ADDRESS<br><i>Lutheran Hospital. 730 Appleton Ave Baltimore</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>   |  | 23b. DATE<br><i>3-31-84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ARBUTUS MEM. PK.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY <i>BALTIMORE MARYLAND</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>E.L. PHILLIPS</i> ADDRESS <i>1721 NORTH MONROE ST.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 3 1984</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>David A. Randall</i>  |  |



1



101

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUSSELL MCGAHA MATHEWS JR.</b>         |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 22, 1984</b>                     |  | 2b. HOUR<br><b>12:29P</b>   |
| 3. SEX<br><b>M.</b>  | 4. RACE<br><b>W.</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 20, 1921</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dairy</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farmer</b>   |   |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Frederick</b>  | 13c. CITY OR TOWN<br><b>Union Bridge</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Russell McGaha Mathews SR</b>       |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucille Titus</b>            |  |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-36-6216</b>  |  | 17. INFORMANT<br><b>Coppermine Rd., Union Bridge, Md</b><br><b>Charlotte S. Mathews, 11623</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**45 min****8 days**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

**Liver failure, pneumonia**

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION<br><b>—</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>17 Mar 19 84</b> to <b>22 Mar 19 84</b> , that (I) (we) last saw the deceased alive on <b>22 Mar 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>R. Lange</b>   | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>3/22/84</b>   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. LANGE MD</b>   |  | 22c. ADDRESS<br><b>The Johns Hopkins Hospital</b>  |  |

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>          | 23b. DATE<br><b>Mar 24, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>D. D. Hartzler, Woodlawn, Md</b> |                                  | 25a. DATE REG'D. BY REGISTRAR / REGISTRAR'S SIGNATURE<br><b>MAR 27 1984 John Davidson-Randall</b> |   |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sophia Matthews</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/ 05/1984</b>               |   |  | 2b. HOUR<br>M<br><b>M</b>  |   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 06 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4004 Greenspring Ave. (21209)</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housekeeper</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Family</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4004 Greenspring Ave. Baltimore, Md. 21209</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H. Rollins</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada Wilson</b>     |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>219-20-5459</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy Mitchell Baltimore, Maryland 21215</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF FATHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January, 19 84</b> , to <b>January, 19 84</b> , that (I) (we) last saw the deceased alive on <b>January 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Elena Barraquer</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elena BARRAQUER</b>   |  |   |  |   | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/10/1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Meadowridge Memorial</b>         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Maryland</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nutter &amp; Sons Funeral Home Inc.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1984</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |  |   |  |
| 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216  |  |   |  |   |  |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

3/05/1984

Address

30115

97

1 01 1987

Black

Female

Baltimore City

X

U. S. A.

Maryland

1000 Greening Ave. (21202)

Homeless

Ext. Family

Baltimore

Ave. Baltimore, Md. 21202

X

Baltimore

Maryland

Wilson

Adm

Kolins

H.

John

3821 Dolefield Ave.

Baltimore, Maryland 21215

No.

Howard Maryland

Park

Memorial Home Inc.

2201 G Street N.W. Baltimore, Md. 21216

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 7 1 8 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thomas MAYS</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 13, 1984</b> |   |  | 2b. HOUR <b>p</b><br><b>10:00</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 25 18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65 years</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>224 W. Lafayette Ave. 21217</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Unkn.</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>242-14-6590</b>  |  | 17. INFORMANT<br><b>Medical Records Department<br/>Maryland General Hospital<br/>Baltimore, MD. 21201 827 Linden Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Stomach</b><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>March 2</b> , 19 <b>84</b> , to <b>March 13</b> , 19 <b>84</b> , that (X) (we) last saw the deceased alive on <b>March 13</b> , 19 <b>84</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.     |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Daniel Schwartz</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/14/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel Schwartz, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>3/20/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |   | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1984</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

10:00

March 13, 1964

APRIL

THURSDAY

42 years

18

11

11

11:00

11:00

Baltimore City

General Hospital

Baltimore

11:15

324 W. Calverton Ave.

x

Baltimore

11:15

General Hospital  
Baltimore, Md.  
324 W. Calverton Ave.

11:15-11:30

Removal of the stomach

xx

March 13  
11:15

March 13

11:15

March 13  
11:15

x

March 13

xx

xxx

xx

3/11/64

x

c/o Maryland General Hospital

General Hospital, M.D.

3/11/64

3/11/64



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07181

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY CATHERINE McCLUNG</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 21, 1984</b>  |  | 2b. HOUR<br><b>11:00<sup>AM</sup></b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 11, 1909</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b><br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3901A Corse Ave.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pharmaceutic</b>                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward C. Griffin</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth M. Brenneis</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>222-14-9812</b>   | 17. INFORMANT<br>ADDRESS<br><b>Georgiale Wilson, 3901A Corse Ave. 21206</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>YRS</b><br><b>YRS</b>                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>HYPOTHYROID</b>   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>2-9-80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HYPOTHYROID</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-1-80</b> , to <b>2-9-80</b> , that (I) (we) last saw the deceased alive on <b>2-9-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Richard W. Bitttrick</b>  |  | DEGREE<br><b>MD</b>  | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Mar. 22, 1984</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard W. Bitttrick, M.D.</b>   |  | 22e. ADDRESS<br><b>8100 Harford Rd.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Mar. 24, 1984</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>   |  |  |
| ADDRESS<br><b>6009 Harford Rd., Balto., Md. 21214</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |                  |   |  |  |
|--|---------|--|--|---|------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | 2a. DATE KNOWN OF DEATH  |   |                  | 2b. HOUR  |  |  |
| JOSEPH WILLIAM MC CURDY  |         |  | MONTH DAY YEAR<br>3 7 1984   |   |                  | 2d. HOUR<br>12:30 p.m.  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  |  |  |
| MALE   | WHITE   | 7 9 31   | 52 YRS.  | MONTHS DAYS   | HOURS MIN.       | 3 7 1984  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |
| VIRGINIA   |         | U.S.A.   |  |   |                  | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Baltimore  |         | University Hosp. (STU)   |  | BUS TRANSPORTOR-BLUE BIRD EAST  |                  |   |  |  |
| 13a. STATE   |         |  | 13b. COUNTY  |   |                  | 13c. CITY OR TOWN   |  |  |
| VIRGINIA   |         |  | ROCKBRIDGE   |   |                  | LEXINGTON   |  |  |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME   |   |                  | 16. SOCIAL SECURITY NO.   |  |  |
| WILLIAM McELEE   |         |  | JOSEPHINE TOLLEY   |   |                  | 228-38-0850   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  | 17. INFORMANT  |   |                  | ADDRESS   |  |  |
| YES  |         |  | GRACE F. McCURDY   |   |                  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:   |         |  |  |   |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Thoracic injuries</u><br>8120<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |                  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |         |  |  |   |                  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |         |  |  |   |                  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |                  |   |  |  |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                  |   |                  | 20. AUTOPSY?  |  |  |
|  |         |  |  |   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:40x 3-7- 1984 |   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |
|  |         |  | Driver in van/truck collision.                                     |   |                  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)        |   |                  | 21f. LOCATION   |  |  |
|  |         |  | road   |   |                  | Beards Hill Rd. & Rt. 22, Aberdeen, Harford, Md.                              |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |  |  |   |                  |   |  |  |
| ACTUAL SIGNATURE   |         |  | TITLE (SPECIFY)  |   |                  | DATE SIGNED   |  |  |
| Ann M. Dixon, M.D.   |         |  | Assistant  |   |                  | 3-8-84  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  | ADDRESS  |   |                  |   |  |  |
| Ann M. Dixon, M.D.   |         |  | 111 Penn St., Balto., Md. 21201                                    |   |                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  | 23b. DATE  |   |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| BURIAL   |         |  | 3/9/84   |   |                  | COLLIERSTOWN PRESBY CEM   |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |  | 25a. DATE REC'D. BY REGISTRAR                                      |   |                  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| T.W. Williams  |         |  | MAR 19 1984  |   |                  | Julia Davidson-Randall  |  |  |
| ADDRESS  |         |  | 25c. REGISTRAR'S SIGNATURE   |   |                  |   |  |  |
| 714 S. MAIN ST., LEXINGTON, VIRGINIA   |         |  |  |   |                  |   |  |  |

RECEIVED  
MAR 19 1964

15 0 5

13



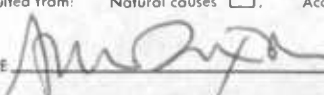
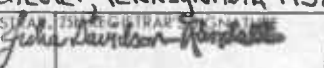
MAR 19 1964

10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |   |  |  |  | REG. NO.  |  |
|--|--|----------------------|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN Thomas MC CUTCHEON</b>   |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>3 11 19 84</b> |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 26, 1951</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>32 YRS.</b>  |  | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 11 19 84</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hosp. (STU)</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Parts Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>   |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY <b>Harford Co.</b>  |  | 13c. CITY OR TOWN <b>Bel Air</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>9 Overbrook Drive 2014</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William Robert McCutcheon</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Anne Snyder</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>213-60-2070</b>   |  | 17. INFORMANT (Full name) <b>Mr. William R. McCutcheon</b> ADDRESS <b>9 Overbrook Drive Bel Air, Maryland 21014</b> |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Perforating gunshot wound of head (handgun)</b><br>9550<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:50 PM 3-11-19 84</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b>                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>auto</b>   |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Fallston Gen. Hosp., Fallston, Harford, Md.</b>                   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE    |  |                      |  | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>3-11-84</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |                      |  | 23b. DATE <b>March 11, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CRAIN &amp; Ferris Crematory</b>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Chester, Pennsylvania 19380</b>   |  |
| 24. FUNERAL DIRECTOR <b>Joseph William Foster</b> ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>  |  |                      |  | DATE RECD. BY REGISTRAR <b>MAR 13 1984</b>       |  |   |  |  |  |   |  |

Handwritten notes and tables, mostly illegible due to fading and bleed-through. Some visible fragments include:

TABLE 1

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 2

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 3

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 4

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 5

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 6

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 7

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 8

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 9

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

TABLE 10

| DATE     | TIME  | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/64 | 10:00 | ...      | ...     |
| 10/10/64 | 11:00 | ...      | ...     |
| 10/10/64 | 12:00 | ...      | ...     |
| 10/10/64 | 13:00 | ...      | ...     |
| 10/10/64 | 14:00 | ...      | ...     |
| 10/10/64 | 15:00 | ...      | ...     |
| 10/10/64 | 16:00 | ...      | ...     |
| 10/10/64 | 17:00 | ...      | ...     |
| 10/10/64 | 18:00 | ...      | ...     |
| 10/10/64 | 19:00 | ...      | ...     |
| 10/10/64 | 20:00 | ...      | ...     |
| 10/10/64 | 21:00 | ...      | ...     |
| 10/10/64 | 22:00 | ...      | ...     |
| 10/10/64 | 23:00 | ...      | ...     |
| 10/10/64 | 24:00 | ...      | ...     |

Vertical text on the right margin, possibly a page number or reference code, appearing as "10/10/64".



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| #FDM, FilmG590 4/19/84 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7184  |                         |  |   |   |                                |   |  |   |                          | REG. NO. |
|--|-------------------------|--|---|---|--------------------------------|---|--|---|--------------------------|----------|
| 1. STATE REGISTRAR   |                         |  |   |   |                                |   |  |   |                          |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Madeleine F. McDonough</b>  |                         |  |   |   |                                |   | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3/20/84 <input type="checkbox"/> |   | 2b. HOUR <b>1:45 P M</b> |          |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 26, 1893</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br><b>3/20/84</b>  |  | 2d. HOUR <b>1:45 P M</b>  |                          |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |                          |          |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3900 N. Charles St.</b> |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                          |          |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3900 N. Charles St.</b> 21218                             |                          |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles J. Blankford Blankford</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia A. Scully</b>   |                                |   |  | 16. ADDRESS<br><b>8406 Maymeadow Ct.</b>  |                          |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>215-22-2209</b>   |   | 17. INFORMANT<br><b>Carolyn McD. Windsor</b>  |                                | 17. ADDRESS<br><b>Baltimore, Md. 21207</b>  |  |   |                          |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>9570<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |                         |  |   |   |                                |   |  |   |                          |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |   |                                |   |  |   |                          |          |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR <b>1:30 P.M.</b> MONTH DAY YEAR<br><b>3/20/84</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>victim precipitated from window</b>                                     |                                |   |  |   |                          |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>terrace</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3900 N. Charles St., Balto. City, Md.</b>   |                                |   |  |   |                          |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |                                |   |  |   |                          |          |
| ACTUAL SIGNATURE<br><b>Gregory R. Kauffman</b>   |                         | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |   |   |                                | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>3/21/84</b>   |                          |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Gregory R. Kauffman, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>  |   |   |                                |   |  |   |                          |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                         | 23b. DATE<br><b>Mar. 22, 1984</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>                   |  |   |                          |          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21201</b>   |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>   |                                | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |   |                          |          |



9 15

DATE: 10/15/70

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 07185   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elmer F. McDowell</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>16</b> YEAR <b>84</b>  |  | 2b. HOUR<br><b>11:40</b> AM   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>April</b> DAY <b>19</b> YEAR <b>1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Yardwork</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Handyman</b>  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>3700 Greenspring Avenue, 21215</b>  |   |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bertha</b> MIDDLE <b>McDowell</b> LAST <b></b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |  | 17. INFORMANT<br>ADDRESS <b>20850</b><br><b>Lucy E. Norris, 233 N. Van Buren Street</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                            |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>SEPTICEMIA</b>  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 27 84</b> , to <b>MARCH 16 84</b> , that (I), (we) lost<br>saw the deceased alive on <b>MARCH 16 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>C. C. ONEJEME MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>3-16-84</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. C. ONEJEME</b>   |   |
| 22e. ADDRESS<br><b>PROVIDENT HOSPITAL</b>  |  |  |  | 22f. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Portsmouth, Ohio</b> COUNTY <b>Sio</b> STATE <b>Ohio</b>                                     |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>WOODLAWN MEMORIAL FH, 6411 Windsor Mill Road</b> ADDRESS <b></b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John D. Anderson</b>  |  |  |  | 25c. REGISTRAR'S SIGNATURE<br><b></b>   |  |   |   |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| FOR<br>1- STATE REGISTRAR   |  |                      |  |  |  |   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO.                                 |  |
|---|--|----------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILLIE C. MCDUFFY</b>  |  |                      |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-26-84 <sup>19</sup>              |  |   |  |  |  |  |  |  |  | 2b. HOUR <sup>M</sup> 2:49A <sup>M</sup> |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 23 04</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>80</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>3-26-84</b> <sup>19</sup>  |  | 2d. HOUR <sup>M</sup> 2:49A <sup>M</sup>  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> <sup>MD.</sup>           |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2205 Westwood Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                      |  | 13a. STATE <b>Maryland</b>   |  |   |  | 13b. COUNTY <b>Baltimore</b>  |  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>John W. Chester</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Clara M. Bishop</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS <b>2205 Westwood Ave. 21216</b>                                 |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>216-01-2323</b>  |  |   |  | 17. INFORMANT <b>Avery McDuffy</b>  |  |  |  | ADDRESS <b>2205 Westwood Avenue</b>   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER   |  |   |  |   |  |  |  | DATE SIGNED <b>3-26-84</b>  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  |                      |  | 23b. DATE <b>3/30/84</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem. Pk.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Laurel, Md.</b>                       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm C March F/H, Inc. 1101 E North Ave.</b>  |  |                      |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b> |  |   |  |  |  |  |  |  |  |  |  |

1

UNITED STATES  
DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's assistant must sign the certificate.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07187

REG. NO.

|   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2. DATE OF DEATH   |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR   |  |  |
| FRANK   |  |  | McFADDEN   |  |  | 03 09 84   |  |  | 01.45 AM   |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                              |  |  |
| Male  |  |  | Black  |  |  | 9 23 27  |  |  | 56 YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |
| S. Carolina   |  |  | U.S.A.   |  |  |  |  |  | Baltimore city MD.   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| city  |  |  | BON SECOURS HOSPITAL   |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. CITY OR TOWN  |  |  | 13c. INSIDE CITY LIMITS?   |  |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |  |
| Maryland  |  |  | Baltimore  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 236 Amity Street 21223   |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |
| Canty   |  |  | McFadden   |  |  | Ethel  |  |  | Alston   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS  |  |  |
| NO  |  |  | N/A  |  |  | Mary A. Clark  |  |  | 1617 N. Ellamont Street  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>pulmonary TB</u>   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (b) <u>alcoholic</u>  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (c)   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |
|   |  |  | P.M. 19  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION  |  |  | CITY OR TOWN COUNTY STATE                                      |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  | STREET   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>84</u> , to <u>3/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED   |  |  |
| <u>Kuang-yen Huang</u>  |  |  | MD   |  |  |  |  |  | <u>3/9/84</u>  |  |  |
| 22d. PHYSICIAN'S NAME (COM. OR REG.)  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |
| <u>KUANG-YEN HUANG</u>  |  |  | <u>BON SECOURS Hospital</u>  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |
| BURIAL  |  |  | 3/13/84  |  |  | Moun t Auburn Cem.   |  |  | Baltimore, Md.   |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| NAME ADDRESS  |  |  |  |  |  | <u>Gina Davidson-Rendell</u>   |  |  |  |  |  |
| <u>Wm C March F/H Inc. 1101 E North Avenue</u>  |  |  |  |  |  | <u>MAR 13 1984</u>   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

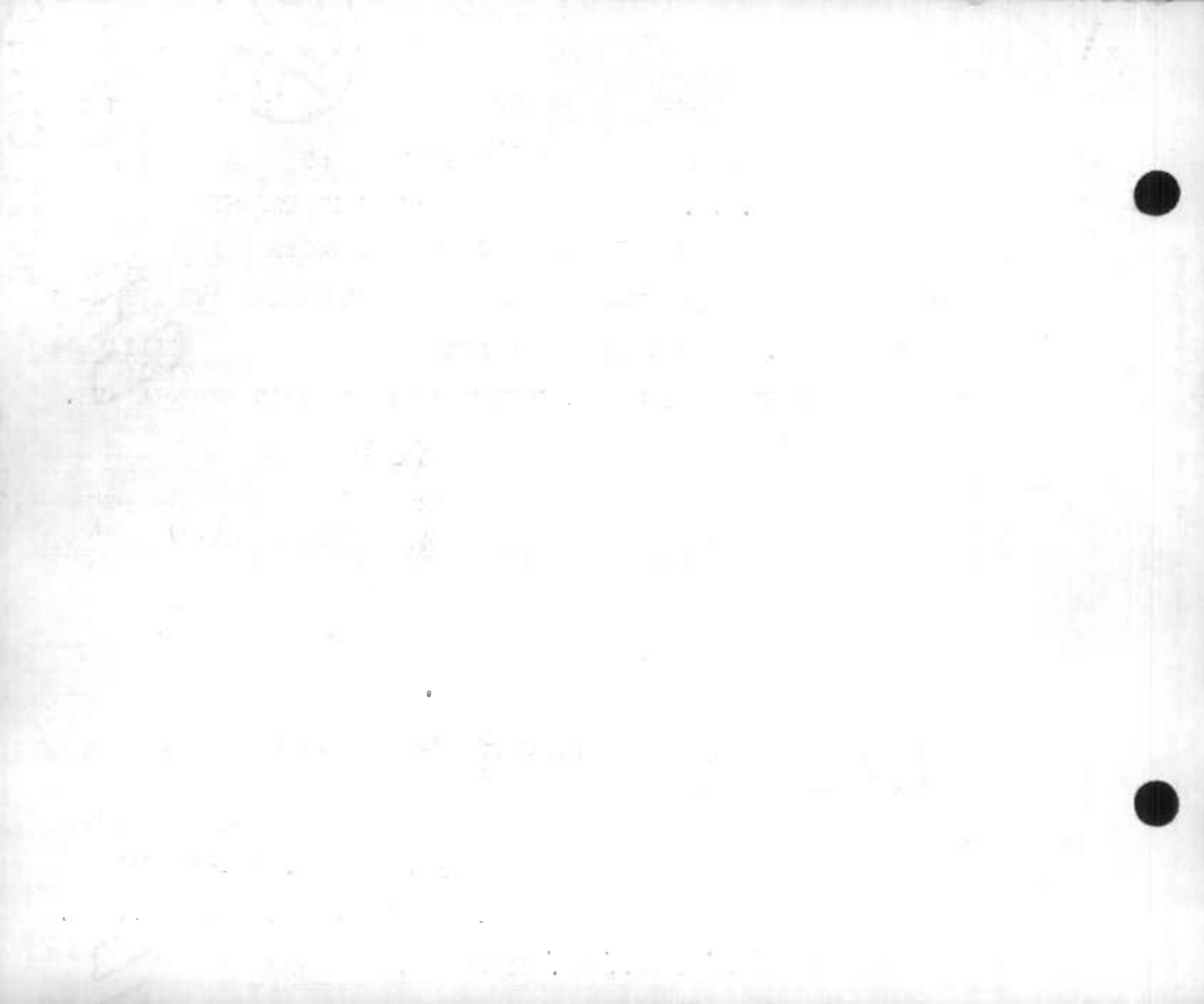
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 7 1 8 8

REG. NO.

|  |  |   |  |  |   |   |                                   |   |  |
|--|--|---|--|--|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John Oliver McGreer  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 14, 1984            |  | 2b. HOUR<br>1:19p M   |   |                                   |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 20 1918  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                              |                                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER BALTIMORE MD |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                                   | 13e. STREET ADDRESS / ZIP CODE<br>201 WARREN AVE APT 4-11 21230 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM F. MCGREER   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MATTIE WILLIAMS |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW II                         |                                   | 16b. SOCIAL SECURITY NO.<br>249 16 2983                         |  |
| 17. INFORMANT<br>HATTIE CAMPBELL/4410 NORFOLK AVE.   |  |   | 17. ADDRESS<br>21216   |  |   | 17. ADDRESS<br>21216  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br><u>5770</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>perforated gastric abscess</u><br>(c) <u>acute pancreatitis, liver abscesses &amp; extension in portal V.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>unk.  |  |   |  |  |   |   |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |  |  |   |   |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |                                   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 27</u> , 19 <u>84</u> , to <u>March 14</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 14</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |   |   |                                   |   |  |
| 22b. SIGNATURE<br>R Panos MD   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                             |   | 22c. DATE SIGNED<br>3/16/84   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R PANOS MD  |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto Md 21218  |  |  |   |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>03/19/84   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST VE   |   | 23d. LOCATION<br>BALTIMORE BALTO., MD. STATE  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MARSHALL W. JONES, Jr.<br>4101 EDMONDSON AVE./BALTO., Md. 21229  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1984   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randell   |                                   |   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), it shows any injury, or other traumatic event, the cause of death may be related to it.

BP

DHMM-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                                   | 07189  |  |
|---|--|--|--|---|--|---|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |                                   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MARY MIDDLE LEE LAST MCKAY<br>MARY LEE MCKAY  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 3/14/84 1984 |   |  |  |                                   | 2b. HOUR<br>10 <sup>10</sup> P M   |  |
| 3. SEX<br>FEMALE<br>FEMALE  |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC 16 1939   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ASSEMBLY WKR  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |  |  |   |  |   |  |  |                                   | 13b. COUNTY  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN LITTLE   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOUELLA STRADFORD   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13. STREET ADDRESS<br>3419 EDMONDSON AVE 21229                                    |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-26-7915   |  | 17. INFORMANT<br>ADDRESS<br>21229   |  | LOUELLA LITTLE/3530 EDMONDSON AVE.  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4549 IMMEDIATE CAUSE (a) MASSIVE BLEEDING -> SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) BLEEDING GASTRIC ULCERS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) LIVER CARCINOMA (Cirrhosis) |  |  |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14/84 to 3/14/84, that (I) (we) last saw the deceased alive on 3/14/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br>L. C. C.  |  |  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br>3/14/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEDWINA CUEO   |  |  |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>03/19/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM. PARK   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTO., M d.              |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME MARSHALL W. JONES, JR.<br>ADDRESS 4101 EDMONDSON AVE. BALTO., Md. 21229  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1984                                      |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |                                   |  |  |

MEDICAL CERTIFICATION



UNITED STATES  
COTTON

TO THE  
HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
IN SENATE  
WASHINGTON, D.C.  
JANUARY 1, 1901  
SIR:  
I HAVE THE HONOR TO ACKNOWLEDGE THE RECEIPT OF YOUR LETTER OF THE 28TH INSTANT, IN WHICH YOU REQUESTED THAT I SHOULD BE KEPT ADVISED OF THE PROGRESS OF THE WORK OF THE COMMISSIONERS OF THE GENERAL LAND OFFICE IN REGARD TO THE LANDS BELONGING TO THE UNITED STATES IN THE TERRITORY OF ARIZONA.  
I HAVE THE HONOR TO ADVISE YOU THAT THE COMMISSIONERS OF THE GENERAL LAND OFFICE ARE AT THE PRESENT TIME ENGAGED IN A CAREFUL EXAMINATION OF THE MATTER, AND WILL BE KEPT ADVISED OF THE RESULTS OF THEIR INVESTIGATION AS SOON AS THEY ARE OBTAINED.  
Very respectfully,  
J. M. SMITH  
COMMISSIONER OF THE GENERAL LAND OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 7190  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>NITA T. MC KENZIE   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH - 1 - 1984  |  | 2b. HOUR<br>2:35 PM  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOV. 10 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>MD.  |  | 13b. COUNTY<br>-   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>5008 E. PRESTON ST. 21205  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>R. LORENZO TAYLOR   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CARRIE B. STONEBERGER   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-26-8036A   |  | 17. INFORMANT ADDRESS<br>HARRY MC KENZIE (SAME ADDRESS)   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE CORONARY ARTERY OCCLUSION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CORONARY ARTERIO SCLEROSIS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>DIABETES MELLITUS - CEREBROVASCULAR INSUFFICIENCY   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (the hospital) attended the deceased from JUNE 19 74, to MARCH 1 19 84, that (1) (we) last saw the deceased alive on 3-1-19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Joseph D. Notarangelo M.D.  |  |  |  | DEGREE<br>M.D., PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>            |  | 22c. DATE SIGNED<br>3-1-1984   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSEPH D. NOTARANGELO M.D.   |  |  |  | 22e. ADDRESS<br>301 ST. PAUL PLACE BALTIMORE  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/5/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |

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20% COTTON

SHIRTS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 7 1 9 1  |  |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Minnie MCKNIGHT  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3/5/84  |  | 2b. HOUR<br>3:40 M   |
| 3. SEX<br>F   | 4. RACE<br>B   | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 12, 1900  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C. Manning   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife                   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY CITY<br>Maryland Baltimore  |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c. STREET ADDRESS<br>4516 Manor Lane Rd  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Billy BRUNSON  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary FELDER                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>Rosita Madison   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>5325 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Septic shock.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Perforated duodenal ulcer. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 days<br>11 days. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br>2/26/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Perforated duodenal abscess  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital, attending the deceased from 2/23/84 to 3/5/84, saw the deceased alive on 3/3/84, and that in (my) (aur) apian death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE<br>J. A. Arrisuezo   |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>3/5/84   |  |
| 22d. PHYSICIAN'S NAME - TYPE CLEARLY<br>J. A. Arrisuezo   |  | 22e. ADDRESS<br>730 Ashburton St.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3-9-84  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MTD.          |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown-Thompson Fitt   |  | ADDRESS<br>1913 W. BALTO. ST.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 14 1984   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |   |  |  |

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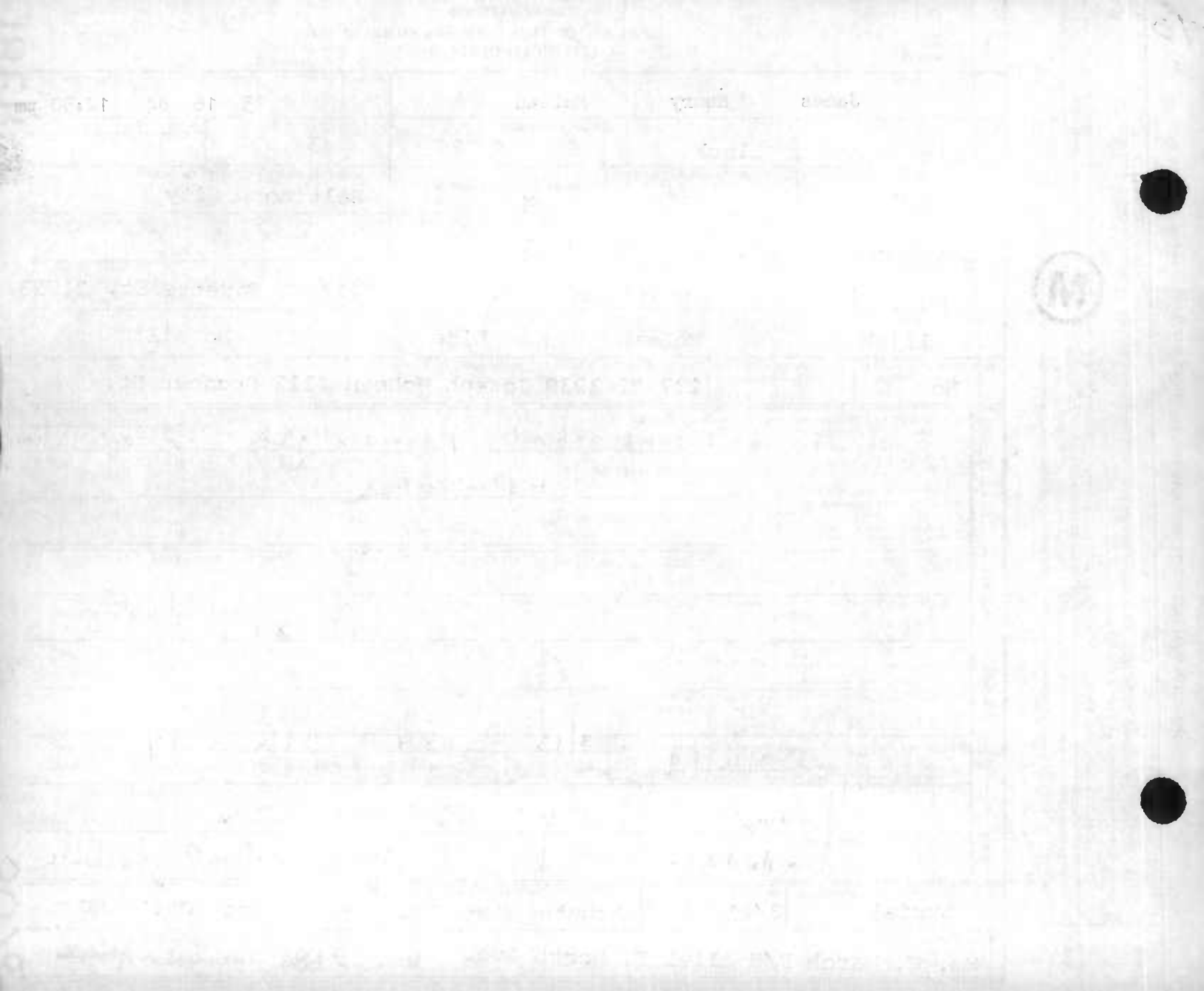
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 1B above any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 07192  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Henry McLean</b>   |  |  |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>16</b> YEAR <b>84</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>4</b> YEAR <b>20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Elijah</b> MIDDLE LAST <b>McLean</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Liza</b> MIDDLE LAST <b>McNeill</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>237-22-3239</b>   |  | 17. INFORMANT ADDRESS<br><b>Joseph McLean 4312 Spencer St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intra cerebral Haemorrhage</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days 14 hours</b>     |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>84</b> , to <b>3/16</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/16/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>K. A. W. N. I.</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><b>St Agnes Hospital, Baltimore, MD</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/21/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore CO. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E, North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. A. Davidson-Randall</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | 7 1 9 3   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CORTIA McLEOD</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 23 89</b>  |  | 2b. HOUR<br><b>6:00 AM</b>   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 8 47</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>37</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>Maryland Baltimore</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS ZIP CODE<br><b>4116 Haywood Ave. 21215</b>  |  |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Carlin Brown</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Helen Woods</b>  |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>073-40-1934</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Carlin Brown 4015 Oakford Ave</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4151 V-tach and electrochemical dissociation</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive pulmonary edema acutely</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive pulmonary embolus? Mitral valve regurg?</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>mitral valve disease, possible MI, STOK acute</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>1.5 hour</b><br><b>1.5 hour</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> 19 <b>89</b> , to <b>3/23</b> 19 <b>89</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/23</b> 19 <b>89</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>E. Zimmerman MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/28/89</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward Zimmerman</b>  |  |   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (C/F)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-28-89</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Joseph L. Russ</b>  |  |   |  | ADDRESS<br><b>2222 W. North Ave.</b>  |  | 25. DATE RECD. BY REGISTRAR<br><b>MAR 27 1989</b>  |   |
|   |  |   |  | 25a. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTHA PEARL McNEILL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>15</b> YEAR <b>84</b> |   |  | 2b. HOUR<br><b>M</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>JUNE</b> DAY <b>7</b> YEAR <b>1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>MIN.</b> |  |
| 7a. BIRTHPLACE<br><b>NORFOLK, Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> <b>City</b> <b>MD</b>                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>MARYLAND GENERAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |
| 13a. USUAL RESIDENCE<br>13a. STATE <b>MD.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2310 Mt. ROYAL TERRACE</b>      |  |
| 14. FATHER'S NAME<br>FIRST <b>M</b> MIDDLE <b></b> LAST <b></b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MELISSA</b> MIDDLE <b>McCLAIN</b> LAST <b></b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>ARTIS McNEILL 2731 HARLEM AVE.</b>                               |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

**4149**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Ischemic heart disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Hypertension**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**30 minutes**

**5 years**

**15 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

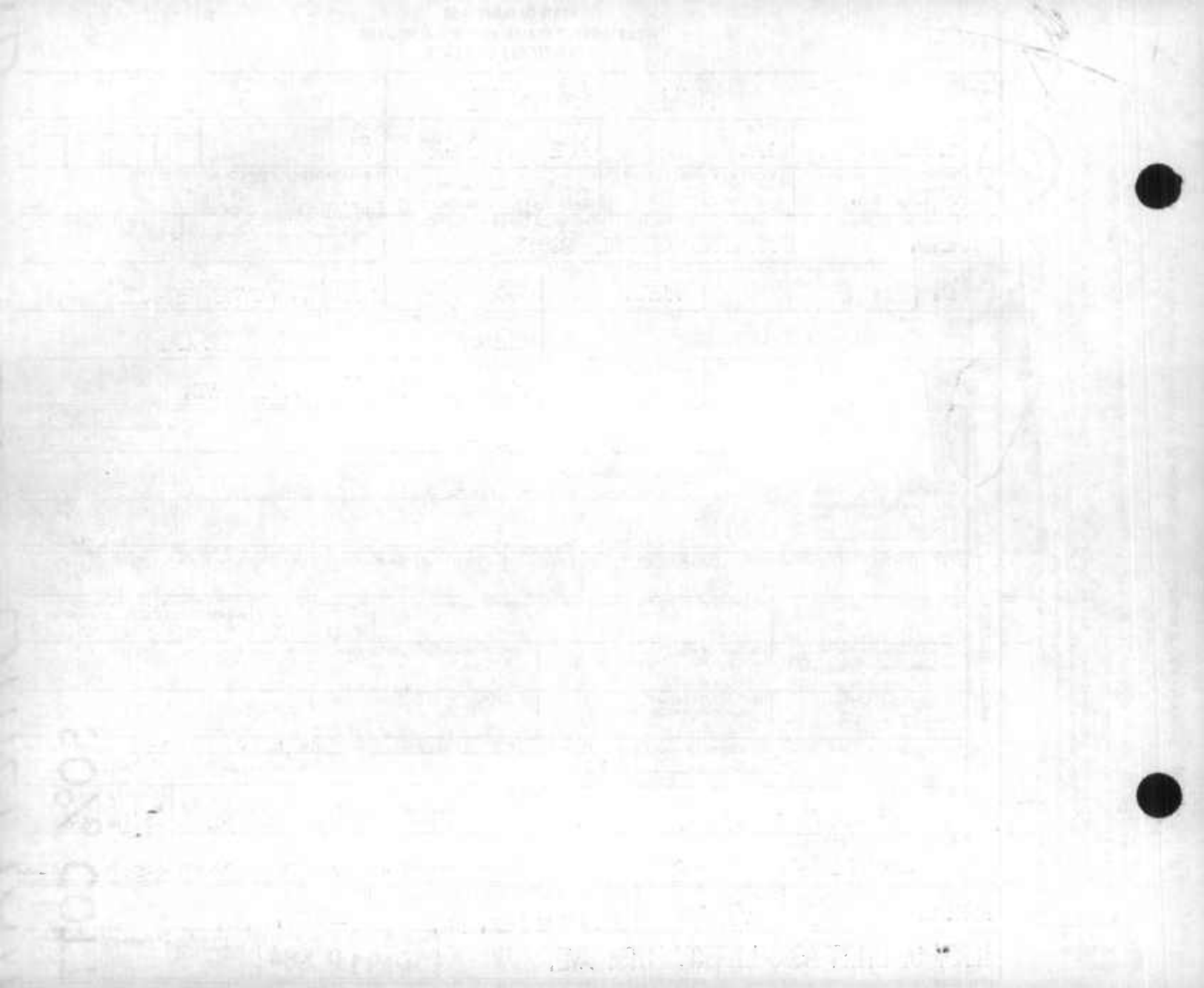
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1983</b> , 19 <b>83</b> , to <b>March 15</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>December 2</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <b>did not</b> view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Daniel E. Ford</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>3/16/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL E. FORD</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21203</b>                    |  |  |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                     |  | 23b. DATE<br><b>3/19/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUS MEM. PK.</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO., Md.</b> COUNTY STATE |  |
| 24. FUNERAL DIRECTOR<br><b>LEROY O. DYETT 4600 LIBERTY HTS. AVE.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>         |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examination can be held and an autopsy is required.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |                |   |  |   |                     |  |  |
|---|--|---|--|--|----------------|---|--|---|---------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>GERTRUDE  | MIDDLE<br>Lena | LAST<br>MEISTER   | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 12, 84 |   | 2b. HOUR<br>12:55 M |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 25, 1909  |                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                     | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |   |                     |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |  |                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store  |                     |  |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore   |                | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     | 13e. STREET ADDRESS<br>2811 Manoff Road 21227  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George F. Meister  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie E. Dahlweiner  |                |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |                     |  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  |   |  | 17 INFORMANT<br>Daughter<br>Catherine M. Schreiber MD  |                |   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u><br>4161<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cor Pulmonale (Pulmonary Hypertension)</u><br>(c) <u>Severe Kyphoscoliosis + Bronchiectasis</u> |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Recurrent Aspiration Pneumonia</u>   |  |   |  |  |                |   |  |   |                     |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 12/31 19 83, to 3/11 19 84, that (1) (we) lost<br>saw the deceased alive on 3/11 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did) did not view the body after death. |  |   |  |  |                |   |  |   |                     |  |  |
| 22b. SIGNATURE<br><u>Dennis M. Smith</u>  |  |   |  | DEGREE<br>MD   |                |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                     | 22c. DATE SIGNED<br>5/12/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DENNIS M. SMITH MD   |  |   |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229  |                |   |  |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>March 14, 84  |                | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie AA MD   |                     |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>A B Vma  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1984   |                |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |                     |  |  |
| Singleton Funeral Home, Glen Burnie, MD   |  |   |  |  |                |   |  |   |                     |  |  |

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

900 CATON AVE. BALTIMORE, MD. 21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "injury or other traumatic event, the medical examiner must be notified at once."

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | 1. DECEASED NAME FIRST MIDDLE LAST<br>CHRISTINE MARYDITH  |  |  |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>3-13-84   |  |   |  | 2b. HOUR MIN.<br>12:45 AM   |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>APRIL 2, 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>EDGEWOOD NURSING HOME |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AT HOME  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. STREET ADDRESS<br>2607 EVERGREEN AVE.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HENRY KALBSKOPF  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SOPHIA HERBERLIN  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>217143711D  |  | 17. INFORMANT ADDRESS<br>FAMILY RECORDS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBRAL VASCULAR INSUFFICIENCY.<br>4379 DUE TO, OR AS A CONSEQUENCE OF<br>(b) H. A. S. C. D.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ARTERIO SCLEROSIS.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>STREET 124/84 to 3/13/84   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13/84 to 3/13/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN<br>Anthony F. Carozza MD  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>3/14/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anthony F. Carozza   |  |   |  | 22e. ADDRESS<br>6000 BOLLINGA Ave Balto MD 21212  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>MARCH 16, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM. PARKVILLE   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MARYLAND   |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS Chapel of Memories   |  | 25. ADDRESS<br>800 HARFORD RD.  |  | 26. PERIOD BY REGISTRAR<br>FEB 23 1984  |  | 27. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

BP



Info. per phone conv.

1- FOR with FH on 3/7/84  
STATE REGISTRAR jlbSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07197

REG. NO.

|  |  |  |   |   |  |  |  |  |  |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lester T. Merryman</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3.4.84</b> |   |  | 2b. HOUR<br><b>5<sup>23</sup> P.M.</b>   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 22 15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>- MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Gov't Employee</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALT.</b>  |   | 13c. CITY OR TOWN<br><b>BALT.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>517 S. WASHINGTON ST.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Emory Merryman</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Bonn</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |   | 16b. <b>577-03-5643</b><br><b>215-09-7720</b>   |  | 17. INFORMANT ADDRESS<br><b>CHRISTINE P. MERRYMAN 517 S. WASHINGTON ST</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b><br><b>4/100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Possible MI Possible CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Anemia, pneumonia</b>   |  |  |   |   |  |  |  |  |  |
| 9a. DATE OF OPERATION  |  | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3.4.1984</b> to <b>3.4.1984</b> , that (I) (we) lost saw the deceased alive on <b>3.4.1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Joseph L. Roche</b>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3.4.84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph L. Roche</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>301 ST. PAUL ST, BALTIMORE, MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/8/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DRUID RIDGE CEM</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO CO, MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Paul E. Chomwith 305 CHERRYBLOT AVE</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>La Davidson-Randall</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07198

|   |  |  |   |  |                                   |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR  |  | 20. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 20. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| HERMAN WILLIAM MEYER  |  | 3 8 84   |   | 4:26 M   |                                   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR   |                                   |
| MALE  | WHITE  | 11 26 94   | 89  | MONTHS DAYS HOURS MIN.   |                                   |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| BALTIMORE   | USA  |  | BALTIMORE CITY MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE   | ST AGNES HOSPITAL  |  | Retired - Sales   |  | Dry Goods                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. STATE   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |  |                                   |
| Maryland  | Baltimore  | Catonsville  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |
| 13e. STREET ADDRESS / ZIP CODE  |  | 13f. STREET ADDRESS / ZIP CODE   |   |  |                                   |
| 5715 Edmondson Avenue   |  | 21228  |   |  |                                   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| Franz A. Meyer  |  | Anna (unknown)   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |
| No  |  | 212-01-7594  |   | 1 N. Morerick Ave. Mrs. Dorothy Scheppske -Baltimore, Md. 21228                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |                                   |
| IMMEDIATE CAUSE (a) Perforated viscous w/ peritonitis + sepsis  |  |  |   |  |                                   |
| 5621  |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                   |
| (b) Diverterculitis of Ischemic bowel disease   |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                   |
| (c)   |  |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |                                   |
| ASCVD w/ CHF  |  |  |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|   |  | HOUR A.M. MONTH DAY YEAR   |   |  |                                   |
|   |  | P.M. 19  |   |  |                                   |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |                                   |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   | STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 March 19 84 to 8 March 19 84, that (I) (we) last saw the deceased alive on 3 March 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| David Jung  |  |  |   |  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |   |  |                                   |
| DAVID JUNG, M.D.  |  |  |   |  |                                   |
| 22e. ADDRESS  |  | St. Agnes Hospital, Baltimore, Md.   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Burial  |  | 3/10/84  |   | Loudon Park Cemetery   |                                   |
| 24. FUNERAL DIRECTOR  |  | 23d. LOCATION  |   | 23e. DATE REC'D BY REGISTRAR   |                                   |
| NAME  |  | CITY OR TOWN   |   | COUNTY STATE   |                                   |
| Witzke General Inc  |  | Baltimore  |   | Md.  |                                   |
| 24b. ADDRESS  |  | 25. REGISTRAR'S SIGNATURE  |   |  |                                   |
| Catonsville Md  |  | MAR 8 1984   |   |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07199

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                                   |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH W. Mikius</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-19-84</b>  |  | 2b. HOUR<br><b>10<sup>55</sup> P<sup>M</sup></b>                  |                                   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 25, 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                 |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Lithuania</b> | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |

|   |             |   |   |  |  |   |  |  |
|---|-------------|---|---|--|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |             |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>929 Kresson St. 21205</b> |  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY | 13c. CITY OR TOWN<br><b>Baltimore</b>           |   |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kazimer Miknius</b>                        |             |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Karpus</b>                          |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |             | 16b. SOCIAL SECURITY NO.<br><b>197-05-1900A</b> |   | 17. INFORMANT ADDRESS<br><b>Charlotte Doelle 2518 Lodge Forest Dr. 21219</b> |  |   |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b><br>IMMEDIATE CAUSE (a) <b>Brain &amp; Lung metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Unknown primary cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

|   |  |  |  |
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| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Severe peripheral vascular disease</b> |  |  |  |
|---|--|--|--|

|  |   |  |   |
|--|---|--|---|
| 19a. DATE OF OPERATION<br><b>2-4-84</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute ischemia (L) leg</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |

|   |  |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02-04</b> , 19 <b>84</b> , to <b>03-19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>03-19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |
|---|--|

|   |                              |                                       |
|---|------------------------------|---------------------------------------|
| 22b. SIGNATURE<br><b>[Signature]</b>                                | DEGREE<br><b>[Signature]</b> | 22c. DATE SIGNED<br><b>3-19-84</b>    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR DENNIS MACDONALD</b> |                              | 22e. ADDRESS<br><b>Mercy Hospital</b> |

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>Mar. 22, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Dundalk, Balto. Co., Md.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
|---|-----------------------------------|---|--|

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b> | ADDRESS<br><b>6500 York Rd.</b> | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 23 1984</b> | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |
|--|---------------------------------|--|--|

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| FIRST MIDDLE LAST  |  |   |  | MONTH DAY YEAR  |  |  |  | MONTHS DAYS HOURS MIN.  |  |   |  |
| ALLAN CARLISLE MILES   |  |   |  | March 3, 1984   |  |  |  | 10 <sup>00</sup> M  |  |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  | 7. IF UNDER 24 HRS.   |  |
| Male   |  | White   |  | MONTH DAY YEAR<br>July 25, 1892   |  | 91 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| MD   |  | USA   |  |   |  | Baltimore City MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| Baltimore  |  | Long Green Nursing Center   |  |   |  | Owner  |  | Produce   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?  |  |  |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |   |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 21210   |  |   |  |
| MD   |  |   |  | Balto.  |  |  |  | 100 W. Cold Spring La.  |  |   |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |
| FIRST MIDDLE LAST<br>Southey F. Miles  |  |   |  | FIRST MIDDLE LAST<br>Mollie B. Miles  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |
| Yes WW I   |  |   |  | 217 05 8664   |  | Mrs. Doris M. Miles, Same  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE</u><br><u>1850</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>17 MONTHS</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>GENERALIZED ARTERIOSCLEROSIS</u>  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
|  |  |   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19 _____  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
|  |  |   |  |   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>MAR 11</u> , 19 <u>84</u> , to <u>MAR 2</u> , 19 <u>84</u> , that (I) (we) last<br>saw the deceased alive on <u>FEB 28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>John M. Scott</u>   |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><u>3/5/84</u>                                   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. John M. Scott, M.D.   |  |   |  | 22e. ADDRESS<br>600 W. Northern Parkway, Balto., MD   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |
| Burial   |  |   |  | 3/5/84  |  | Druid Ridge  |  | Pikesville, MD  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>4905 York Road Balto., MD  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1984                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>                  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

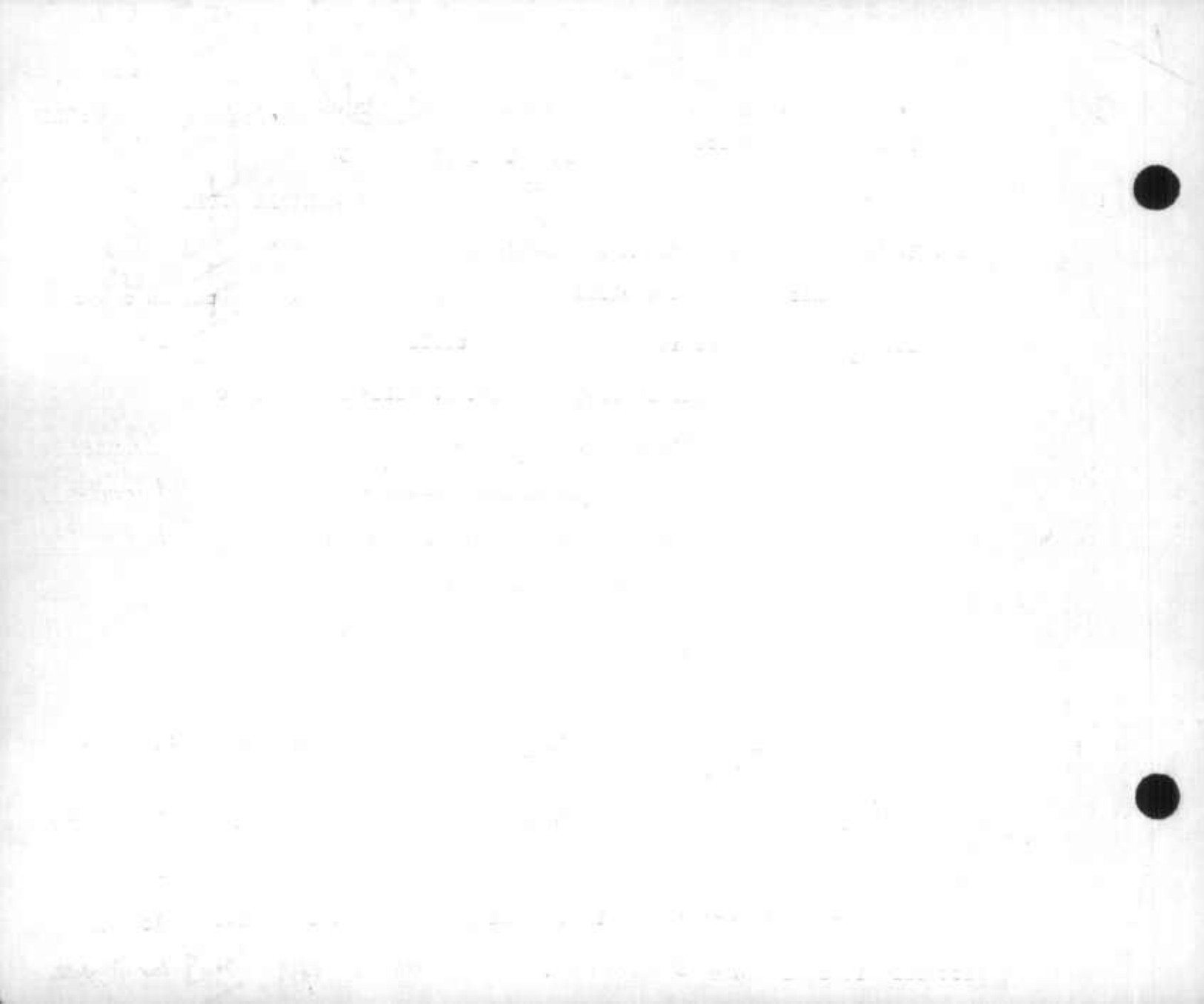


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached and used for the burial-transit permit. The permit is removed from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, a traumatic event, or the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | REG. NO.  |  |
|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARGARET P MILES  |   |   | MARCH 5, 1984   |  | 6:22 PM   |  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 18 1947  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>D.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Homemaker                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13b. CITY OR TOWN Balto  |   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>1809 Notre Dame Ave 21093 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William D. Patrick   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Estelle Flynn                                  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |   | 16b. SOCIAL SECURITY NO.<br>215 52 5592   |   | 17. INFORMANT ADDRESS<br>Eugene L. Miles 3rd Same  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>2051<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic pulmonary infiltrates</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic myelocytic leukemia</u>   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>40 min<br>1 month<br>15 months   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Bone marrow transplant</u>   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br>—  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Feb 6</u> , 19 <u>84</u> , to <u>Mar 5</u> , 19 <u>84</u> , that (1) (we) lost<br>saw the deceased alive on <u>Mar 5</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) did (did not) view the body after death. |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Steven R. Cohen</u>   |   | DEGREE<br><u>M.D.</u>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>3-5-84</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Steven R. Cohen</u>  |   | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |   | 23b. DATE<br><u>3/8/1984</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Dulaney Valley Mem Gds</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Cockeysville Balto Md</u>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Mitchell-Wiedefeld Hpme</u>   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 8 1984</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   |
|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2. DATE OF DEATH  |   |
| W allace Miles  |   | 07/20/84  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |
| Male  | Black   | 7 4 1900  | 84 83 YRS.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |
| N. Carolina   | U.S.A.  |   | Baltimore City MD.  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |
| Baltimore   | The Johns Hopkins Hospital  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| 13a. STATE  |   | 13b. COUNTY   | 13c. CITY OR TOWN   |
| Maryland  |   | Baltimore   | Baltimore   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |
| L ite Miles   |   | M artha Miles Lee   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS   |
| NO  |   | 215-01-2950   | Doris Jamison 4610 Lawnpark Rd. Apt. A                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>   |   |   | 5 minutes   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable New Stroke</u>   |   |   | 3 days  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration Pneumonia</u>  |   |   | 2 months  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |   |
| <u>Multi infarct Dementia</u>   |   |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
|   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
|   |   |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/8</u> , 19 <u>84</u> , to <u>3/20</u> , 19 <u>84</u> , the <u>11</u> (we) lost<br>saw the deceased alive on <u>3/20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If I (we) did not) view the body after death. |   |   | 22c. DATE SIGNED  |
| 22b. SIGNATURE<br><u>Paul Katzenstein</u> MD  |   |   | 3/20/84   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |   | 22e. ADDRESS  |
| PAUL KATZENSTEIN  |   |   | Johns Hopkins Hospital  |
| 23a. BURIAL, CREMATION, REMOVAL   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |
| BURIAL  | 3/26/84   | Baltimore Cemetery  | Baltimore, MD.  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR   |   |
| Wm C March F/H Inc, 1101 E North Avenue   |   | MAR 21 1984   |   |
|   |   | REGISTRAR'S SIGNATURE<br><u>John Davidson-Russell</u>   |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07203

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |                                |  |   |                                 |  |
|--|--|--|--|--|--|--|--------------------------------|--|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRIET RUTH MILLER   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 31 84                        |  |  | 2b. HOUR<br>8:10 PM  |                                |  |   |                                 |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 31 35   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.                                   |                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                   |                                |  |   |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTIMORE |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERICAL |                                | 12b. KIND OF ADMINISTRATION<br>INDUSTRY<br>SOCIAL SECURITY   |   |                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  |  |  | 13b. COUNTY<br>OWINGS MILLS  |  | 13c. CITY OR TOWN<br>BALTIMORE |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Miller   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Frank   |  |                                |  |   | 16. ADDRESS<br>Mills, Md. 21117 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No.  |  |  | 16b. SOCIAL SECURITY NO.<br>215-30-7740                                |  | 17. INFORMANT<br>Miss Lita S. Miller   |  |                                | 18. ADDRESS<br>Richmar Apts. Apt. E-1  |   |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5559 IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) Crohn disease; Pyoderma |  |  |  |  |  |  |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |                                |  |   |                                 |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                |  |   |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                                |  |   |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 27, 1984, to March 31, 1984, that (I) (we) last saw the deceased alive on March 31, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |  |  |  |                                |  |   |                                 |  |
| 22b. SIGNATURE<br>MICHAEL WISTER   |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                | 22c. DATE SIGNED<br>03-31-84   |   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL WISTER  |  |  |  |  | 22e. ADDRESS<br>SINAI HOSPITAL OF BALTIMORE  |  |                                |  |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>APRIL 1, 1984   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MIKRO KODESH BETH ISRAEL   |  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.   |   |                                 |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD.  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>APR 6 1984   |  |                                | 26. REGISTRAR'S SIGNATURE<br>John Davidson   |   |                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



100% COTTON

CHELSEA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |                              |   |  | REG. NO.  |  |
|---|--|--|--|---|--|---|------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harry Alfred Miller</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 19 84</b> |   | 2b. HOUR<br><b>10:45P</b> M. |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 15 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |                              | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                              |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Home, Inc.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                              | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS / ZIP CODE<br><b>1027 Cathedral 21201</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul L. Miller</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie A. Argabright</b>  |  |   |                              |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>unknown</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Doris M. Smith 1809 Alexander St.<br/>Midtown Home 808 St. Paul St.</b>  |  |   |                              |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>POSSIBLE MYOCARDIAL INFARCTION,</b><br><b>1522</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA ileum, with METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>TO THE LIVER</b><br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>CA Bladder, ileostomy, possible GI obstruction</b> |  |  |  |   |  |   |                              |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                              | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |                              |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                              |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/02</b> , 19 <b>84</b> , to <b>03/19</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>03/19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |                              |   |  |   |  |
| 22b. SIGNATURE<br><b>Starunique, MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |                              | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |                              |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>   |  | 23b. DATE<br><b>3/20/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>                           |                              |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |                              |   |  |   |  |

BP

03 10 10:45

Miller

11 Yrs

Male

White

03 12

Baltimore City

U.S.A.

U.S.A.

Midtown Home, Inc.

Baltimore

107 Cathedral

Baltimore

Male

800 SE. Paul St.

Midtown Home

11-11-03

Unknown

Yes

Carolina Lane, with neighbors  
to the street  
possible hydroplaning  
accident

CA Brother, Kentucky, possible GI obstruction

03

03/19

03

03/03

03


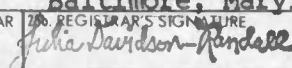
03/19

Ambridge, Ind

0 7 2 0 5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                         |  |   |  |  |  |  |  |   |  |  |  |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                         |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Michael Miller</b>  |  |                         |  |   |  |  |  |  |  | 3-31 1984   |  | M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 22 1955</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>28 YRS.</b> |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br><b>3-31 1984</b>                                |  | 2d. HOUR<br><b>3:55 p.m.</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1800 blk. Longwood Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Car Man</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O road</b>         |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2900 Ellicott Drive Baltimore, Maryland 21216</b> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lassiter Miller</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Hyla Lee</b>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b><br>16b. SOCIAL SECURITY NO. <b>220-64-8722</b><br>17. INFORMANT <b>Janice J. Miller</b> ADDRESS <b>2900 Ellicott Dr. Baltimore, Maryland 21216</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot Wound of Chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                         |  |   |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR <b>3:46 p.m.</b> MONTH DAY YEAR <b>3-31 1984</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was shot</b>   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>on street</b>   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1800 blk. Longwood Street, Balto., Maryland</b>   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |   |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE    |  |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |  |  |  | DATE SIGNED <b>4-1-84</b>  |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>4/5/1984</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans Cemetery</b>   |  |   |  |  |  |
| 23d. LOCATION CITY OR TOWN<br><b>Baltimore, Maryland</b>   |  |                         |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 4 1984</b>  |  |  |  | 23f. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>   |  |                         |  |   |  |  |  |  |  |   |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE BURIAL, CREMATION, OR REMOVAL INFORMATION IN ITEM 23. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DATE: 12-2-78

TO: SAC, NEW YORK

FROM: SAC, BALTIMORE

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]



3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "B" shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                     |   |  | REG. NO.   |  |  |  |
|---|-------------------------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |                                     |   |  | 07206  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>IVY M. MILLER   |                                     |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-13-84  |  | 2b. HOUR<br>8:27 AM  |  |
| 3. SEX<br>Female  | 4. RACE<br>White                    | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 16 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>baltimore city MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL 21218                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |                                     |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas P. Harrison   |                                     |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice M. Shuler  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |                                     | 16b. SOCIAL SECURITY NO.<br>214-14-2722   |  | 17. INFORMANT ADDRESS<br>Mrs. Sharon Brechtel 3518 Roland Avenue 21211   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br><u>4280</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>decompensated COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic renal failure; anemia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> |                                     |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 8</u> , 19 <u>84</u> , to <u>MARCH 13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MARCH 13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                                     |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Theodore J. Kramer MD</u>  |                                     |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3-13-84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THEODORE KRAMER, M.D.  |                                     |   |  | 22e. ADDRESS<br>THE UNION MEMORIAL HOSPITAL  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                                     | 23b. DATE<br>3/16/84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Park   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>A. Alan Seitz, Jr.   |                                     |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAR 16 1984 <u>John Davidson</u>   |  |  |  |

85



WAR 1964

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
- CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JEANNE K. Miller</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-13-84</b> |   |  | 2b. HOUR<br><b>12<sup>35</sup> PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 13 27</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>56</b><br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY Hospital</b>                        |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore City</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Baltimore Timonium</b> |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13c. STREET ADDRESS - ZIP CODE<br><b>2007 Pot Spring Road 21093</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry F. Kniesche</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Irene Myers</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-22-9530</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. Samuel J. Miller Jr. 2007 Pot Spring Rd. 21093</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br><b>4301</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Intracerebral Hematoma</b><br>(c) <b>Ruptured Aneurysm</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>March 13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Cateven M.D.</b>   |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/13/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Cateven, Jim</b>   |  | 22e. ADDRESS  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-16-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Maus.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Baltimore Maryland</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, notify duty injury, or other traumatic event, the medical examiner must be notified.

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City of New York  
 Department of Health  
 Division of Sanitation  
 Bureau of Inspection  
 Office of the Chief Inspector  
 110 West 12th Street  
 New York, N.Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07208

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |   |  |  |
|---|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY E MILLER</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03 30 84</b>                                   |  |  | 2b. HOUR<br><b>8:45 AM</b>   |   |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 21 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                              |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>-</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>1822 W. LOMBARD ST 21223</b>   |  |  |   |  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert JACKSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CLARA BROWN</b>                   |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unkn.</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>900-59-5059</b>  |  | 17. INFORMANT ADDRESS                              |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>0000 IMMEDIATE CAUSE (a) Cerebral aneurysm</b>  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |   |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>3/13/84</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fracture L Hip</b>             |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                     |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b> |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>21093</b>                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/29/84</b> to <b>03/30/84</b> , that (I) (we) last saw the deceased alive on <b>03/29/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Wilima</b>   |  |  | 22c. DATE SIGNED<br><b>3/30/84</b>  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILIMA</b>                               |   |  |  |
| 22e. ADDRESS<br><b>1905 YORK Rd 21093</b>   |  |  |   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>   |  |  | 23b. DATE<br><b>4/2/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 4 1984</b> |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel Miller</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 2 84</b>  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 10 98</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Chauffeur</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jarrett Miller</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Mack</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-03-1915</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Anna Nelson 2745 Riggs Ave., 21217</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>congestive heart failure</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>84</b> , to <b>3/2</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Paul Mullen MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/2/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MULLEN MD</b>   |  |   |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/6/84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. Brown</b>  |  |   |  | ADDRESS<br><b>1206 W North Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1984</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-336-1111.

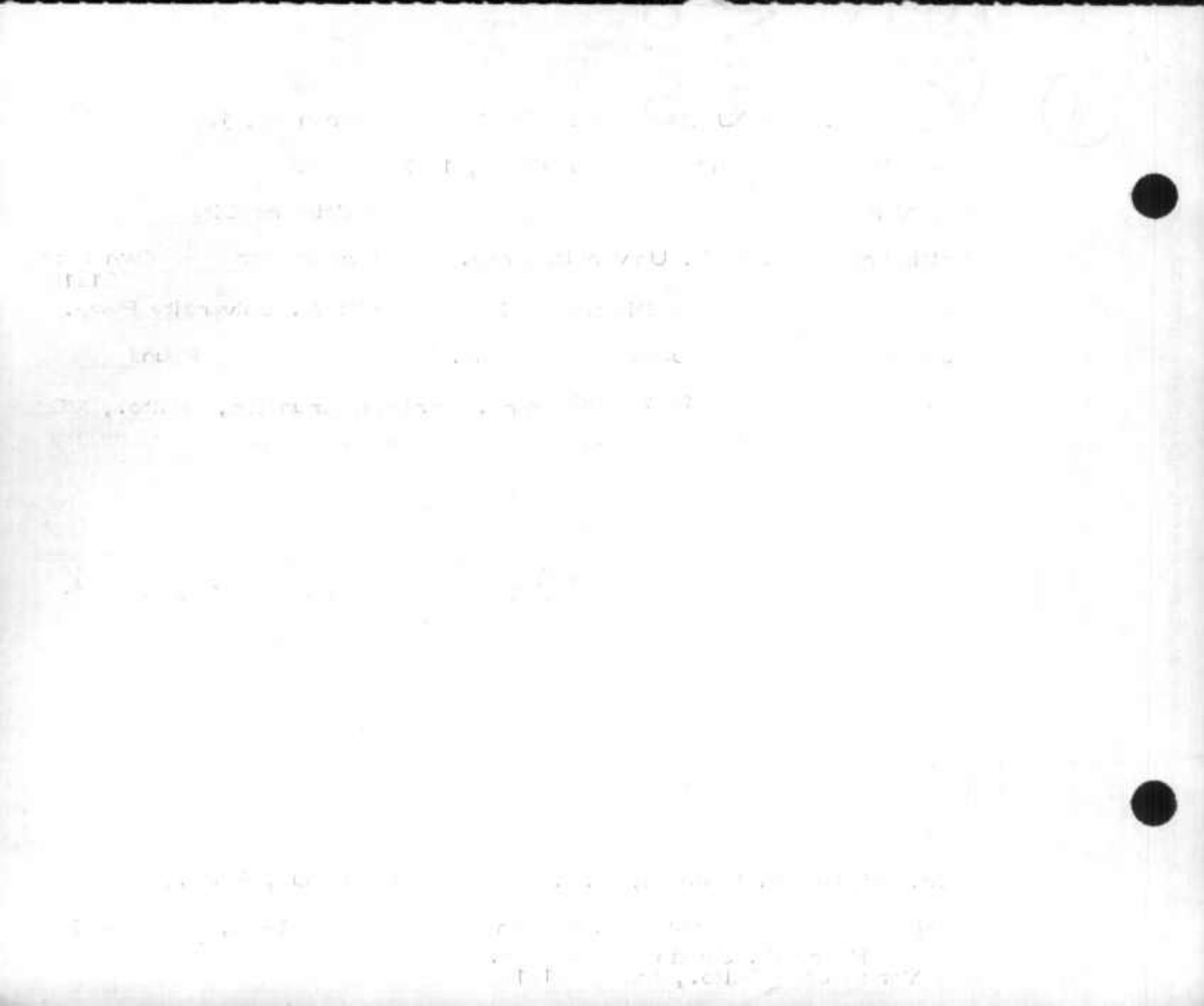
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

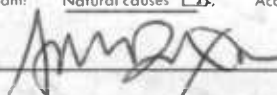
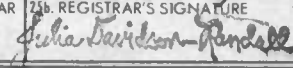
|   |  |  |   |   |                                 |   |   |  |
|---|--|--|---|---|---------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>M. PAULINE MILLIKIN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 22, 1984     |   | 2b. HOUR<br>10 <sup>00</sup> AM |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 29, 1987   |                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>902 W. University Prky. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Bulkley   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>N. Pound |   |                                 |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 16 6006   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Marianne Brundige, Balto., MD  |                                 |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Pulmonary Edema<br>(c)<br>Aortic Aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF<br>(d)<br>Aortic Aneurysm       |  |  |   |   |                                 |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br>Broncho-pneumonia - terminal  |  |  |   |   |                                 |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                 |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22/84 to 3/22/84, that (I) (we) last saw the deceased alive on 3/22/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |   |   |                                 |   |   |  |
| 22b. SIGNATURE<br>Dr. William G. Helfrich, M.D.   |  | 22c. DEGREE<br>M.D.  |   | 22d. ATTENDING PHYSICIAN<br>MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                   |                                 | 22e. DATE SIGNED<br>3-23-84   |   |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William G. Helfrich, M.D.  |  | 22g. ADDRESS<br>5006 Roland Avenue, Balto., MD   |   |   |                                 |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/24/84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, MD  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1984  |                                 |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |   |   |                                 |   |   |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE(S) 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM FM-10-B (REAR PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |                                |   |  |   |                        | REG. NO.  |  |
|--|-------------------------|---|--|---|--------------------------------|---|--|---|------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEAN MILOWANOWIC</b>  |                         |   |  |   |                                |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 3 16 1984 |   | 2b. HOUR<br>10:40 a.m. |   |  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 22 1907</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>76</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD<br>3 22 1984   | 7d. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                     |   | 7e. HOUR<br>10:40 a.m. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VERMONT</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                   |                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>301 McMechen St.</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>  |                        |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>301 McMECHEN ST.</b>  |                        |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEVI TURNER</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE UNKNOWN</b>   |                                |   |  | 17. INFORMANT<br>ADDRESS<br><b>4505 BRIARWOOD LANE OMAHA, NEBRASKA 68147</b>  |                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 16c. SOCIAL SECURITY NO.<br><b>059-16-4020</b>  |                                | 17. INFORMANT<br><b>STEPHEN T. CHUCHKA</b>  |  | ADDRESS<br><b>4505 BRIARWOOD LANE OMAHA, NEBRASKA 68147</b>   |                        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                         |                         |   |  |   |                                |   |  |   |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |                                |   |  |   |                        |   |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |                        |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                       |                        |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                                |   |  |   |                        |   |  |
| ACTUAL SIGNATURE<br>  |                         |   |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>  |                                |   |  | DATE SIGNED <b>3-22-84</b>  |                        |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |                         |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |                                |   |  |   |                        |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |                         |   |  | 23b. DATE<br><b>3-28-84</b>   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS, INC</b>                              |  |   |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CATONSVILLE BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MARZULLO FUNERAL SERVICE</b>  |                         |   |  | ADDRESS<br><b>REISTERSTOWN, MD</b>  |                                |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 28 1984</b>   |                        |   |  |
|  |                         |   |  |   |                                |   |  | 25b. REGISTRAR'S SIGNATURE<br> |                        |   |  |

NOV 11 11:11 AM



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07212

1- FOR  
STATE  
REGISTRAR

Wilhelmina Mines

REG. NO.

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Wilhelmina MINEs  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-2-84  |   |   | 2b. HOUR<br>1037 PM  |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 03 08  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland USA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. Hosp |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME  |  |
| 13a. STATE<br>MD   |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br>6602 Greenoch Dr. 21228                            |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES MOHR   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE MULLER  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>212-07-9684  |   | 17. INFORMANT<br>ADDRESS<br>8602 GREENOCH DR.<br>CHRISTOPHER MINES CATONSVILLE, MD. 21228 |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5860 CHF (Congestive heart failure)<br>DUE TO, OR AS A CONSEQUENCE OF (b) renal failure<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>N/A  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from March 2, 19 84, to March 2, 19 84, that (I) (we) last saw the deceased alive on March 2, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>James F. Knudsen, MD   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>3/2/84   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James F. Knudsen, MD  |  |   | 22e. ADDRESS<br>U. Md. Hospital  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>MARCH 6, 1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE CEMETERY                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DORSEY MARYLAND |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LeRoy M. & Russell C. Witzke Funeral Home  |  |   | 25. DATE REC'D. BY REGISTRAR<br>MAR 5 1984   |   |   | REGISTRAR'S SIGNATURE<br>John Davidson-Randall                                       |   |  |  |
| 1630 Edmondson Ave. Catonsville, Md. 21228   |  |   |  |   |   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07213

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BEATRICE MINIKOVE</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3-6-84</b> |   |  | 2b. HOUR <b>3:50 P.M.</b>  |  |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>CAUC.</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>4-13-29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Sencon</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13a. COUNTY <b>BALTO</b> |  | 13c. CITY OR TOWN <b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE <b>7026 WALLIS AVE 21215</b>                  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>AARON FRIEDMAN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE SHUDOF SKY</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>220-20-3593</b>  |  | 17. INFORMANT ADDRESS <b>MARTIN MINIKOVE 7026 WALLIS AVE. BALTO., MD 21215</b>  |  |  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **METASTATIC CARCINOMA BREAST**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **PROBABLE INFECTION; PANCYTOPENIA**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HOW BY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/11/81</b> P.M. 19 <b>84</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/6/84</b> to <b>3/6</b> 19 <b>84</b> that (I) (we) last saw the deceased alive on <b>3/6/84</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on this date and hour and from the causes stated above. (I have) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. LEONARD LICHTENFELD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>3/6/84</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>MAR. 7, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CHEVRA AHAVAS CHESED</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN BALTO. MD</b>   |  |

24. FUNERAL DIRECTOR **SOL LEVINSON & BROS., INC.**  
NAME ADDRESS **6010 REISTERSTOWN RD. BALTO., MD 21215**

25a. DATE REC'D. BY REGISTRAR **MAR 9 1984**  
25b. REGISTRAR'S SIGNATURE **Julia Davidson-Rendell**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07214

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT MITCHEL</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 15, 1984</b>   |   |   | 2b. HOUR<br><b>5:50A<sub>M</sub></b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 15, 1943</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Howard</b>   |   | 13c. CITY OR TOWN<br><b>Ellicott City</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kenneth Mitchel</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Mercedes</b>  |   |   | 13. STREET ADDRESS / ZIP CODE<br><b>9351 Furrow Court 21043</b>                      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>181 34 8074</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs Kimberlee Mitchel 9351 Furrow Ct 21043</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><b>2050</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Multiple infection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute myelogenous leukemia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 wks</b><br><b>6 months</b> |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 4</u> , 19 <u>84</u> , to <u>MARCH 15</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Daniel Ford, M.D.</u>   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><u>3/15/84</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DANIEL FORD, M.D.</u>  |  |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21205</u>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>March 17'84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Maryland</b>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke</b>  |  |  | 4112 Columbia Rd Ellicott City   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |

MEDICAL CERTIFICATION

Harry H. Wick  
SIT Columbia St. Lincoln City  
March 27, 1944  
Honor. Earl Warren

Dear Mr. Warren:  
I am writing you today to  
express my sincere  
appreciation for the  
information you have  
furnished me regarding  
the activities of the  
various groups and  
individuals who are  
active in the  
Lincoln County area.  
I am sure that this  
information will be  
of great value to you  
in your investigation  
of the activities of  
these groups and  
individuals.

Very truly yours,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |   |
|---|--|---|--|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |   |
| CLARENCE M. MITCHELL, Jr.   |  |   |  | MARCH 18, 1984  |  |  |  | 8:32 AM   |  |   |   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE   |  | 7. IF UNDER 1 YEAR  |  | 7. IF UNDER 24 HRS  |   |
| Male  |  | Black   |  | 3 8 1911  |  | 73 YRS.  |  | MONTHS  |  | DAYS  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |   |
| Maryland  |  | U. S. A.  |  |   |  | Baltimore City MD.   |  |   |  |   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |   |
| Baltimore   |  | Maryland General Hospital   |  |   |  | Attorney   |  | Law   |  |   |   |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                    |   |
| Maryland  |  |   |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1324 Druid Hill Ave. Baltimore, Md. (21217)                       |   |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |   |
| Clarence M. Mitchell Sr.  |  |   |  | Elsie Davis   |  |  |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |   |
| No.   |  |   |  | 081-24-8197-A   |  | Mrs. Juanita Jackson Mitchell  |  | 1324 Druid Hill Ave. (21217)  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>  |  |   |  |   |  |  |  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |   |  |   |   |
| (b) <u>Cardiomyopathy</u>   |  |   |  |   |  |  |  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |   |  |   |   |
| (c) <u>Anoxic Encephalopathy</u>  |  |   |  |   |  |  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |  |   |  |   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |
|   |  |   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY STATE  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 18</u> , 19 <u>84</u> , to <u>March 18</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 18</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  | 22c. DATE SIGNED  |  |   |   |
| 22b. SIGNATURE<br><u>Bruce Shames</u>   |  |   |  | DEGREE<br><u>MD</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 3/18/84   |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BRUCE SHAMES M.D.</u>   |  |   |  | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>  |  |  |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY STATE  |   |
| Cremation   |  |   |  | 3/23/1984   |  | Loudon Park Cemetery   |  | Baltimore,  |  | Maryland  |   |
| 24. FUNERAL DIRECTOR <u>Nutter &amp; Sons Funeral Home Inc.</u><br>NAME ADDRESS<br>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Shea Davidson-Randall</u>          |  |   |   |
|   |  |   |  |   |  | MAR 23 1984  |  |   |  |   |   |

2201 Gwynne Hall Prop. Baltimore, Md. 21218

Walter E. Jones Funeral Home Inc.  
Crestview 5/23/1964 Towson Park Cemetery Baltimore, Maryland

c/o Maryland General Hospital

March 18 84 x  
March 18 84 x  
March 18 84 x

Anoxic Encephalopathy

Cardiovascular

Intracranial Hemorrhage

No.

081-24-8197-A Mrs. Juanita Jackson Mitchell (21217)

1934 Bryn Mawr Ave.  
Charles M. Mitchell Sr. 3 Blais  
Davis

Baltimore

Maryland General Hospital

Attorney  
1934 Bryn Mawr Hill  
Av. Baltimore, Md. (21217)

Maryland

U. S. A.

X

March 18 84

73

CLARK, W. MITCHELL, ST. MARCH 18, 1984

2-12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, it should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GERTRUDE L. MITCHELL</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 09, 1984</b>   |   | 2b. HOUR<br><b>06:20AM</b>                                       |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 15 1914</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br><b>3021 BELMONT AVE. 21216</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES LONG</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORA KENT</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   | 16b. SOCIAL SECURITY NO.<br><b>579 30 9867</b>  | 17. INFORMANT<br>ADDRESS<br><b>REV. DAVID L. MITCHELL 3021 BELMONT AVE.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>0</b>      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>RIGHT URETERAL DUCT STONE WITH NEPHROSTOMY</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  | COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 3</b> to <b>84</b> , to <b>MAR 9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>MAR 9</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Kevin Boylan</b>   |   | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>MAR 9 84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEVIN BOYLAN</b>  |   | 22e. ADDRESS<br><b>M.D. THE JOHNS HOPKINS HOSPITAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>3/14/84</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST VET CEM</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OWINGS MILLS (BALTO.) MD.</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>  |  |

BP


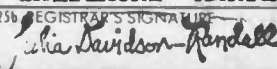
12 1314 50  
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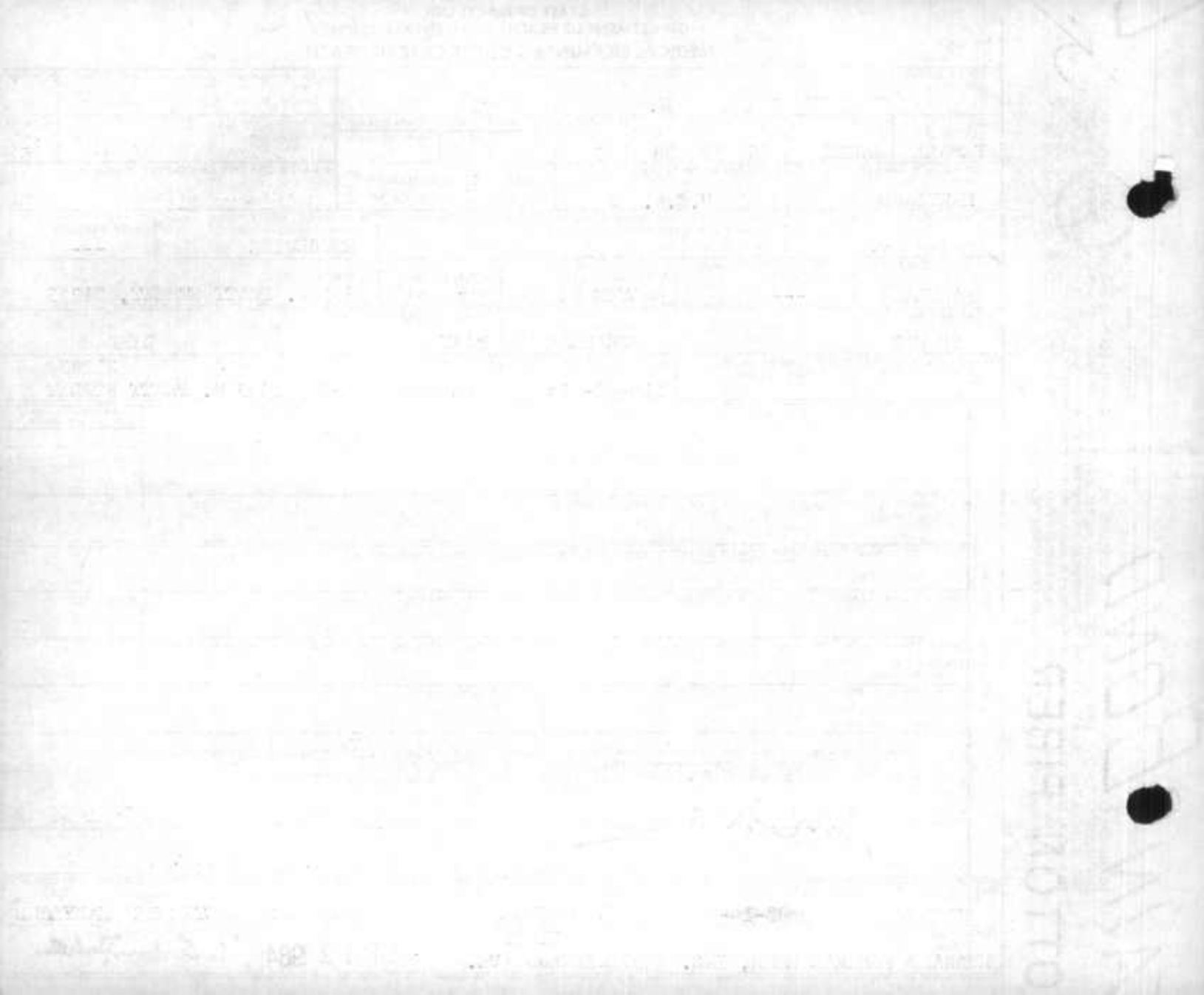
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (S))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |   |  |   |  | REG. NO.   |  |
|---|--|----------------------|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE M. MONCK</b>   |  |                      |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 10 1984</b>  |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>06 17 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.          |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>3 10 1984</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |
| 11. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>   |  |
| 13a. STATE <b>MARYLAND</b>  |  |                      |  |   |  |   |  |   |  | 13b. COUNTY <b>---</b>   |  |
| 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |                      |  |   |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS <b>1605 W. PRATT STREET, 21223</b>  |  |                      |  |   |  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>THOMAS SPEARMAN</b>   |  |                      |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>MARY ZIMNAK</b>                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  |   |  |   |  |   |  | 16b. SOCIAL SECURITY NO. <b>214-01-8342</b>  |  |
| 17. INFORMANT <b>FREDERICK MONCK</b>  |  |                      |  |   |  |   |  |   |  | ADDRESS <b>1605 W. PRATT STREET</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease with sepsis</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                    |  |                      |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |   |  | DATE SIGNED <b>3-11-84</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                      |  | 23b. DATE <b>03-14-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTIMORE MARYLAND</b>                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1984</b>        |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07218

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                            |   |
|--|--|---|--|---|----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Nannie R Monroe</i> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>03 08 84</i> |   | 2b. HOUR<br><i>8:15 PM</i> |   |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>B</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>03 01 16</i>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto - City</i> MD.                                 |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>M.I.E.M.S.S. NTU.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>domestic</i>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><i>md.</i>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Balto -</i>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George Carter</i>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Hattie Ball</i>   |  | 17. INFORMANT (Name) ADDRESS<br><i>Michie, Sylvia 5722 Plainview Ave</i>  |                            |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>     |  | 16b. SOCIAL SECURITY NO.<br><i>217-12-0177</i>  |  | 17. INFORMANT (Name) ADDRESS<br><i>Michie, Sylvia 5722 Plainview Ave</i>  |                            |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4310

IMMEDIATE CAUSE (a) *Cardio-Respiratory Arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Intracerebral Hematoma*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Hypertension*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/16</i> , 19 <i>83</i> , to <i>3/8</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>March 8</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>J. P. Cateven</i> M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>3/8/84</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>CATEVENES</i>   |  |  |  | 22e. ADDRESS<br><i>MIEMSS NTU 22 S. Greenest Balto. Md. 21201</i>  |  |   |  |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> | 23b. DATE<br><i>3/12/84</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King Mem, Pk.</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co., Md.</i> |
|---|-----------------------------|--|---|

|   |   |  |
|---|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H</i> | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 13 1984</i> | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i> |
|---|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and an autopsy requested.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07219

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAISEY H. MONTGOMERY   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/22/84                              |   |  | 2b. HOUR<br>5:50 PM  |  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 1895   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL 21218 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mt. Vernon Mill     |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>3532 Keswick Rd. 21211 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Robinson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sephron A. Eaton   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-07-6407  |   | 17. INFORMANT<br>ADDRESS<br>Leona Harden 3532 Keswick Rd. 21211                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>High blood pressure, Diabetes</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes<br>2 weeks |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Longestive heart failure, peripheral vascular disease</u>   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>—             |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> , 19 <u>84</u> , to <u>3/22</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Marion K. Stomberg MD</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br>3/22/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARIE STOMBERG   |  | 22e. ADDRESS<br>Union Memorial Hospital   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/26/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>A. Alan Seitz, Jr. 3818 Roland Ave. 21211   |  |   |   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07220

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH</b>                        |  |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>13</b> YEAR <b>84</b> |  |  | 2b. HOUR <b>845 PM</b>   |  |  |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>N</b>   |   | 5. DATE OF BIRTH MONTH <b>11</b> DAY <b>2</b> YEAR <b>1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>                |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY BALTIMORE MD.</b>                               |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI Hosp</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b></b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY <b></b>            |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b></b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2126 Ashland Avenue 21205</b> |  |
| 14. FATHER'S NAME FIRST <b>Benjamin</b> MIDDLE <b></b> LAST <b>Edwards</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Lizzie</b> MIDDLE <b></b> LAST <b>Collins</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> |  | 16b. SOCIAL SECURITY NO. <b>247-38 1226</b>  |   | 17. INFORMANT ADDRESS <b>Herman Wade 2126 Ashland Avenue</b>   |  |  |  |  |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac Arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Sepsis, Dehydration.**(c) 

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>3</b> DAY <b>13</b> YEAR <b>84</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)        |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION STREET <b>312</b> CITY OR TOWN <b>84</b> COUNTY <b>84</b> STATE <b></b> |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> 19 <b>84</b> , to <b>3/13</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>E Edwards</b>  |  |  |  | DEGREE <b></b>  |  | 22c. DATE SIGNED <b>3/13/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E Edwards</b>   |  |  |  | 22e. ADDRESS <b>SINAI Hosp of Bto.</b>  |  |   |  |

|   |  |                          |  |  |  |   |  |
|---|--|--------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>                                    |  | 23b. DATE <b>3/18/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>La Vance Cem.</b>                                  |  | 23d. LOCATION CITY OR TOWN <b>Huger,</b> COUNTY <b></b> STATE <b>S.C.</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b> |  |                          |  | 25a. DATE REC'D. BY REGISTRAR <b>15 1984</b> REGISTRAR'S SIGNATURE <b>J. H. Davidson</b> |  |   |  |

TO HOSPITAL, ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MADE IN U.S.A.  
MADE IN U.S.A.



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MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |  |                            |
|--|--|--|--|---|---|--|---|--|--|----------------------------|
| REG. NO.   |  |  |  |   |   |  |   |  |  |                            |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BABY BOY MOORE NICHOLAS</b> <b>MOORE</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>21</b> YEAR <b>84</b>                      |  |   |  |  | 2b. HOUR<br><b>9:35 PM</b> |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>10</b> YEAR <b>84</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>—</b> MONTHS <b>—</b> DAYS <b>11</b>      |   | 7. IF UNDER 1 YEAR<br>HOURS <b>—</b> MIN. <b>—</b>   |  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MARYLAND</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BABY</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |  |                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>135 Virginia Md. in County Baltimore</b>  |  |  |  |   | 13b. CITY OR TOWN<br><b>univ. balto.</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>911 Leadenhall St. 99999 21230</b> |  |  |                            |
| 14. FATHER'S NAME<br>FIRST <b>unknown</b> MIDDLE <b>Lafayette</b> LAST <b>Lawrence</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>April</b> MIDDLE <b>Nadine</b> LAST <b>Moore</b> |  |   |  |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>NA</b>  |  | 17. INFORMANT<br>ADDRESS <b>CARTER CTR UNIV. MESA</b><br><b>MOTHER APRIL MOORE</b>  |   |  |   |  |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio respiratory failure</b><br><b>7690</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>severe Respiratory Distress Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>prematurity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |   |  |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |   |  |   |  |  |                            |
| 19a. DATE OF OPERATION<br><b>none</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>NONE</b> 19 <b>84</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>NONE</b>  |   |  |   |  |  |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b>  |  | 21f. LOCATION<br>STREET <b>N/A</b> CITY OR TOWN COUNTY STATE  |   |  |   |  |  |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 March</b> , 19 <b>84</b> , to <b>21 Mar</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>21 Mar</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |                            |
| 22b. SIGNATURE<br><b>Martha H. Sheridan MD</b>   |  |  |  |   | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>21 Mar 84</b>   |  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>martha G. Sheridan</b>   |  |  |  |   | 22e. ADDRESS<br><b>22 S. Greene St. Balt, Md.</b>                                     |  |   |  |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-26-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO</b> COUNTY STATE <b>MD.</b>      |  |  |                            |
| 24. FUNERAL DIRECTOR<br>NAME <b>WEINER FUNERAL HOME</b> ADDRESS <b>5311 EDMOND AVE</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1984</b>                                   |  |   |  |  |                            |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |   |   |  |   |  |  |                            |



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அதிகாரம்

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07222

1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William F. Moore  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 16, 1984                     |   |   | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 4 1899   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1500 E. 29th Street |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Court                       |  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Moore  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellen Dolan  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-03-9991   |  | 17. INFORMANT ADDRESS<br>Margaret M. Moore 1500 E. 29th St. 21218   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i><br>4100 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Atherosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/19/74</u> to <u>3/16/84</u> , that (I) (we) last saw the deceased alive on <u>3/16/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Meridith Smith M.D.</i>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/16/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Meridith Smith M.D.  |  |  |  |   |   | 22e. ADDRESS<br>1900 E. Northern Parkway Baltimore, Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Mar. 19, 1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck, Inc. Baltimore, Maryland   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)<br>MAR 19 1984 <i>John Davidson-Randall</i>   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07223

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |  |  |
|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM MARTIN MOORE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 07 84</b>            |   | 2b. HOUR<br><b>1:26PM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/25/1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BRAKEMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br>_____  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JESSE T. MOORE</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA HOWE</b> |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-2838</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>EMIL P. MOORE 1121 BUNBURY WAY BALTO. MD 21205</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>5188</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>no respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>End stage interstitial lung disease</b>                             |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>5 min</b><br><b>Years</b>                               |  |
|  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Previous myocardial infarction</b>   |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/6</b> , 19 <b>84</b> , to <b>3/7</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>M.G. Threlkeld</b>  |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.G. Threlkeld</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore MD</b>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>3/8/1984</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY, MARYLAND</b>                                |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER BROOKS BRADLEY INC. DUNDALK, MD</b>  |  | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John G. ...</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate is not to be detached from the death certificate. It is to be retained by the hospital or attending physician. It should be attached for use as the burial-transit permit. Then please remove carbon copies. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.



*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph letter or document.]*

*[Faint text lines visible across the page, including what might be a header, a salutation, and several paragraphs of body text.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Charles J. Moran Sr.</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 - 20 - 89</i> |   |  | 2b. HOUR<br><i>8<sup>30</sup> AM</i>  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 26 08</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>75</i>                        |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD                        |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital, Balto. Md.</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Truck Driver</i> |  |

|  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i> |  | 13b. COUNTY<br><i>Baltimore</i>                |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1409 Patapco St. Balto. Md. 21230</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John William Moran</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Minnie Iowa Hall</i> |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-09-1538</i> |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Anna G. Moran, Same as above</i>     |  |   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i><br><i>4360</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

|   |  |  |  |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><i>Sepsis, pneumonia, seizures.</i> |  |  |  |
|---|--|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

|   |  |                        |  |  |  |
|---|--|------------------------|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/20/89</i> 19 <i>89</i> to <i>3/20</i> 19 <i>89</i> , that (I) (we) last saw the deceased alive on <i>3/20</i> 19 <i>89</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) <i>view the body after death</i> |  |                        |  |  |  |
| 22b. SIGNATURE<br><i>St. Martin</i>   |  | DEGREE                 |  | 22c. DATE SIGNED<br><i>3/20/89</i>                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>St. Martin</i>  |  | ADDRESS<br><i>Mary</i> |  | 22e. REGISTRAR'S SIGNATURE<br><i>John Davidson</i> |  |

|  |  |                                   |  |  |  |  |  |
|--|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Mar. 22, 1984</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</i> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 23 1984</i>              |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                       |  |

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1995-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO.  |  |   |  |   |
|--|--|--|--|--|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>SHIRLEY Rosa MORENO.</u>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>3 8 84</u> 2b. HOUR<br><u>6:25 A M</u> |  |   |  |   |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>Black</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10 11 33</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>50</u> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><u>50</u>  |   |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>North Carolina</u>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><u>U.S. A.</u>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.   |   |  |   |
| 12. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNIVERSITY OF MARYLAND</u> |  |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Computer Operator</u>  |   | 15. KIND OF BUSINESS OR INDUSTRY<br><u>Corp of Army Engineers</u>  |   |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Baltimore</u>  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><u>3614 W. Belvedere Ave 21215</u>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Ernest Marrow</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Rosa Statewhite</u>  |   |  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>               |   |
| 17. SOCIAL SECURITY NO.<br><u>244 54 5277</u>  |  |  |  | 18. INFORMANT<br><u>Sheryl W. Marrow</u>   |   |  |   | 19. ADDRESS<br><u>3614 W. Belvedere Ave.</u>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br><u>4151</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>probable PULMONARY EMBOLUS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>45 min</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><u>DIABETES, HIGH BLOOD PRESSURE</u>   |  |  |  |  |   |  |   |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |   |  |   |
| 22b. SIGNATURE<br><u>Jeanne McCauley</u>   |  |  | DEGREE<br><u>M.D.</u>  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>3/8/84</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JEANNE MCCAULEY</u>  |  |  | 22e. ADDRESS<br><u>22 S. GREENE AVE. BALTIMORE MD. 21201</u>           |  |   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  |  | 23b. DATE<br><u>Mar. 12, 1984</u>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cemetery</u>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Maryland</u> |  |   |
| 24. FUNERAL DIRECTOR<br><u>Nutter and Sons</u>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 14 1984</u>                    |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u>  |   |  |   |
| 25c. ADDRESS<br><u>2501 Gwynns Falls Pkwy.</u>   |  |  | 25d. CITY OR TOWN<br><u>Baltimore, Md.</u>                             |  |   | 25e. STATE<br><u>21216</u>   |   |  |   |

Walter and Sons  
Funeral Home, Inc.

Baltimore, Md. 21216  
2501 Gwynns Falls Hwy.

Mar. 12, 1954 Mt. Auburn Cemetery  
Baltimore

Burial

Maryland

No

24 SA 5277

Sheryl W. Harris

3614 E. Belvidere Ave.

State of

Harriet

Harris

Rosa

State of

Baltimore

X

Maryland

Computer Operator Army Engineers

Cor. of

Post

Jack

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Swain

A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07220

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH D. MORFE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 13 84<br>2b. HOUR<br>6 <sup>40</sup> P M |  |  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 2, 1908   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76<br>YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES REP.    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CO.<br>MACK TRUCK |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  | 13c. STREET ADDRESS / ZIP CODE<br>3129 WEAVER AVE 21214                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>D. MORFE   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>A. CHICITELLI  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 015347   |   | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>4415<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Exsanguination<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ruptured aortic aneurysm<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>3/13/84  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ruptured aortic aneurysm  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13 19 84, to 3/13 19 84, that (I) (we) last saw the deceased alive on 3/13 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>M. Jumbelic  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>3/13/84  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARY I. JUMBELIC, M.D.  |  | 22e. ADDRESS<br>THE UNION MEMORIAL HOSPITAL   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MARCH 16, 1984   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO-MARYLAND   |  | 23e. NAME OF FUNERAL DIRECTOR<br>EVANS CHAPEL OF MEMORIALS HARFORD RO.  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS CHAPEL OF MEMORIALS HARFORD RO.  |  | 25a. DATE RECEIVED BY REGISTRAR<br>MARCH 23 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>John E. ...  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either "While at work" or "Not while at work," the medical examiner must be notified at once.

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |                                |  |   |  |
|---|--|--|--|---|--|---|--------------------------------|--|---|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.   |   |                                |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ruth H Morrison  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-30-84                                     |   |                                | 2b. HOUR<br>5:55 P.M.  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 18 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87   |                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |                                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL OR NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Jenkins Memorial Home<br>1000 S. Caton Ave. 21229 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home maker  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY<br>-----   |   | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John S. Harner  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Bowman                       |   |                                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -----  |  |  | 16b. SOCIAL SECURITY NO.<br>212-34-0671                                |   | 17. INFORMANT<br>Mrs. Kathleen Serio<br>2 Willow Brook Ct. Randallstown, Md. 21133 |   |                                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) PNEUMONIA WITH SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>(c) CVA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 WKS<br>5 YRS<br>1 YR. |  |  |  |   |  |   |                                |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |                                |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |   |                                |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |                                |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from DEC 7, 1983, to MAR 30, 1984, that (I) (we) last saw the deceased alive on MAR 30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |                                |  |   |  |
| 22b. SIGNATURE<br>John F. Hartman   |  |  | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/><br>DIRECTOR PHYSICIAN <input type="checkbox"/> |                                | 22c. DATE SIGNED<br>3-30-84  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN F. HARTMAN  |  |  | 22e. ADDRESS<br>JENKINS NURSING HOME<br>1000 S. CATON AVE. 21229       |   |  |   |                                |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>4-2-84  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland   |                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, Maryland 21133  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 3 1984   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randell   |                                |  |   |  |

BP

60473

DMOEF

W/47471

APR 3 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

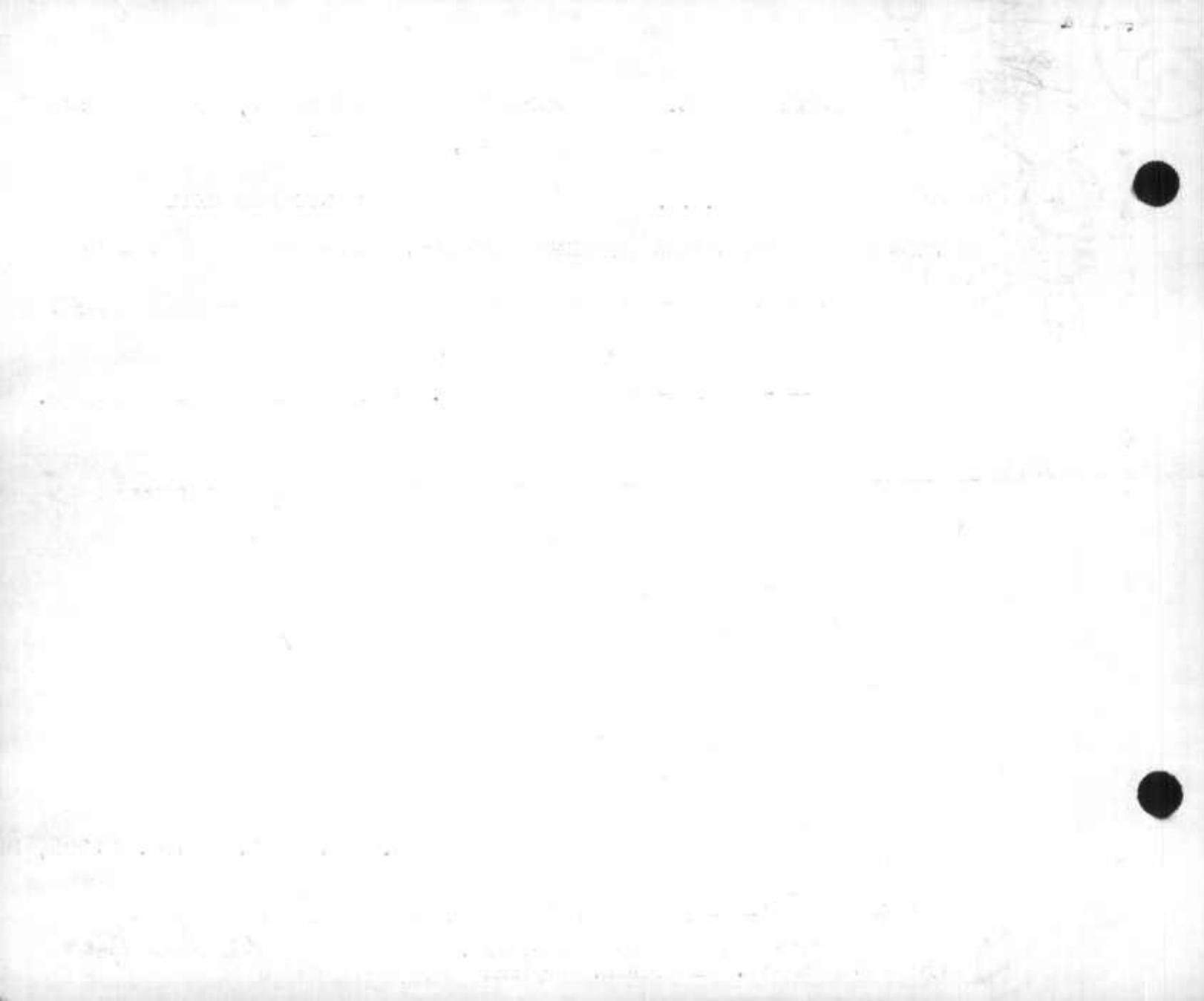
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07228

|  |                              |   |  |  |  |  |  |                  |  |       |  |
|--|------------------------------|---|--|--|--|--|--|------------------|--|-------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR         |  | A M   |  |
| IRVIN  |                              | L. MORTON   |  | MARCH 21, 1984   |  |  |  | 3:45             |  | A     |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |       |  |
| Male   | White                        | December 27, 1910   |  | 73   |  | MONTHS DAYS  |  | HOURS MIN.       |  |       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                  |  |       |  |
| Canada   | U.S.A.                       |   |  | BALTIMORE CITY   |  |  |  |                  |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                  |  |       |  |
| BALTIMORE  |                              | THE JOHNS HOPKINS HOSPITAL  |  | Jeweler  |  | Jewelry  |  |                  |  |       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                              | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |                  |  |       |  |
| Maryland   |                              | Allegany  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 860 Camden Avenue  |  |                  |  | 21502 |  |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |                  |  |       |  |
| FIRST MIDDLE LAST  |                              | FIRST MIDDLE LAST   |  |  |  |  |  |                  |  |       |  |
| Max  |                              | Mortkovitch   |  | Ethel  |  | unknown  |  |                  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                              | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  |                  |  |       |  |
| No   |                              | 212-32-8383   |  | Maxine B. Frey, daughter   |  | same as 13a-e.   |  |                  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4411<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Ruptured thoracic Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Multiple emboli 2° to TAA.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>2 days</u> |                              |   |  |  |  |  |  |                  |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Metabolic Acidosis, Renal Failure</u>  |                              |   |  |  |  |  |  |                  |  |       |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |       |  |
| 3/19/84  |                              | Ruptured Thoracic Aortic Aneurysm   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                  |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |                  |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>(STREET CITY OR TOWN COUNTY STATE)  |  |  |  |                  |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> 19 <u>84</u> to <u>3-21</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                              |   |  |  |  |  |  |                  |  |       |  |
| 22b. SIGNATURE   |                              | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |                  |  |       |  |
| Wm C Dooley MD   |                              |   |  |  |  | 3/21/84  |  |                  |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              | 22e. ADDRESS  |  |  |  |  |  |                  |  |       |  |
| Wm C Dooley MD   |                              | 600 N. WOLFE ST. BALTO. 21205, MD   |  | Johns Hopkins Hospital   |  |  |  |                  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>(CITY OR TOWN COUNTY STATE)                   |  |                  |  |       |  |
| Burial   |                              | 3-22-84   |  | East View Cemetery   |  | Cumberland Allegany MD   |  |                  |  |       |  |
| 24. FUNERAL DIRECTOR   |                              | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                  |  |       |  |
| NAME Leasure-Stein Funeral Home, Inc.<br>230 Baltimore Ave. Cumberland, Maryland   |                              | MAR 27 1984   |  | John A. Harrison   |  |  |  |                  |  |       |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07229

| 1. FOR STATE REGISTRAR   |  |  | REG. NO.   |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>MARGARET MORTON</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 10 84</i>  |   |  |
| 3. SEX<br><i>F</i>   |  |  | 4. RACE<br><i>B</i>  |   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 05 13</i>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.  |   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>   |  |  | 7c. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY, MD.</i>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>MERCY HOSPITAL</i> |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><i>Maryland</i>  |  |  | 13b. COUNTY<br><i>Baltimore</i>  |   |  |
| 13c. CITY OR TOWN<br><i>Baltimore</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |   |  |
| 13e. STREET ADDRESS<br><i>3204 Sequoia Avenue 21215</i>  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Otis Curry</i>  |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Margaret Rusk</i>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>                      |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>215-40-7519</i>   |  |  | 17. INFORMANT<br>ADDRESS<br><i>Ernestine Stewart 1810 N. Smallwood St</i>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hepato Renal Failure</i><br><i>4280</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Severe congestive heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><i>Hemorrhagic tract sepsis</i>  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><i>3/10/84</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Hemorrhagic tract sepsis</i>  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/17</i> , 19 <i>84</i> , to <i>3/10</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>3/10</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Stephen D. Campbell MD</i>  |  |  |  | 22c. DATE SIGNED<br><i>3/10/84</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Stephen D. Campbell MD</i>   |  |  |  | 22e. ADDRESS<br><i>Mercy Hospital<br/>301 ST. PAUL AVE<br/>BALTO. MD 21202</i>      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>   |  | 23b. DATE<br><i>3/15/84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Garrison Forest VA</i>                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Owing Mills. Md.</i>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm C March F/H Inc. 1101 E North Avenue</i>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 13 1984</i>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jana Davidson-Randall</i>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must file a certified copy of the report with the State Dept. of Health and Mental Hygiene.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, FIELD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |   |   |   |   |   |  |  |   |                          |  |
|--|-------------------------|---|---|---|---|---|--|--|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George Mosley</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> 3 DAY 22 YEAR 84 |   |   | 2b. HOUR<br>M 5:25  |  |  |   |                          |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <input checked="" type="checkbox"/> 76 DAY YEAR   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 YRS.</b>                                     | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH 3 DAY 24 YEAR 84                                      |  |  | 2d. HOUR<br>M 5:25  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                      |  |  |   |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>901 W. Saratoga Street</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>(Soc. Security)</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY          |   |                          |  |
| 13a. STATE<br><b>Md.</b>   |                         |   | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>901 W. Saratoga St. 21223</b>                             |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Mosley</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ka Laura</b>                      |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO, OR UNKNOWN) <b>No</b>          |  |  |   | 16b. SOCIAL SECURITY NO. |  |
| 17. INFORMANT<br><b>Ms. Annie Mosley</b>   |                         |   | ADDRESS <b>1619 1/2 Division Balto., Md.</b>  |   |   |   |  |  |   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |   |   |   |   |  |  |   |                          |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |   |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |   |                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                           |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |  |   |                          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |  |  |   |                          |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>   |   |   | MEDICAL EXAMINER  |  |  | DATE SIGNED <b>3/25/84</b>  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn St. Balto., MD.</b>  |   |   |   |  |  |   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |                         |   | 23b. DATE<br><b>4/17/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |                         |   |   |   | ADDRESS<br><b>Balto., Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1984</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                         |                          |  |



WM S 894

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |   |  |  |   |   |                            |
|---|--|--|---|--|--|---|--|--|---|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |   | 2b. HOUR  |                            |
| CARMELO   |  |  | MOTTO   |  |  | MARCH 5, 1984   |  |  |   | 10:31 AM  |                            |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |                            |
| Male  |  |  | Caucasian   |  |  | Oct. 8, 1912  |  |  | 71 YRS.   |   |                            |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                            |
| Maryland  |  |  | USA   |  |  |   |  |  | Baltimore City, MD.   |   |                            |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                            |
| Baltimore   |  |  | Church Home Corp.   |  |  | Millwright  |  |  | Western Elec.   |   |                            |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |   |                            |
| Md.   |  |  | -   |  |  | Baltimore   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  | 13e. STREET ADDRESS   |  |  | Balto, Md.  |   |                            |
| Dominic Motto   |  |  | Mary  |  |  | 102 N. Kenwood Ave, 21224   |  |  |   |   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS   |   |                            |
| Yes   |  |  | 213-10-4422   |  |  | Teresa M. Motto   |  |  | 102 N. Kenwood Avenue   |   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <del>MYO</del> MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CORONARY ARTERY INSUFFICIENCY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ANTERIOR SCLEROTIC CARDIOVASCULAR DISEASE |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |  |  |   |  |  |   |   |                            |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |   |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |                            |
| 22. I certify that (I) (this hospital) attended the deceased from MAR. 4, 19 84, to MAR. 5, 19 84, that (I) (we) lost<br>saw the deceased alive on MAR 5, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.            |  |  |   |  |  |   |  |  |   |   |                            |
| 23a. SIGNATURE<br>AHMED NOUR MD   |  |  |   |  |  |   |  |  | 23b. ADDRESS<br>CHURCH HOSPITAL<br>100 N. BROADWAY BALTO. MD 21231  |   | 23c. DATE SIGNED<br>3/5/84 |
| 23d. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23e. DATE   |  |  | 23f. NAME OF CEMETERY OR CREMATORY  |  |  | 23g. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |                            |
| Burial  |  |  | 3/9/84  |  |  | Gardens of Faith  |  |  | Baltimore, Md.  |   |                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |   |                            |
| SCHIMUNEK FUNERAL HOME, 3331 Brehms La,   |  |  |   |  |  | MAR 6 1984  |  |  | Julia Davidson-Randall  |   |                            |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the Medical Examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07232

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JESSE SCOTT MOYER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 18, 1984</b> |   |  | 2b. HOUR<br><b>7:08 AM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 11 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b><br>YRS. MONTHS DAYS HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5010 THE ALAMEDA</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b> |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK MOYER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE TINSLEY</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5010 THE ALAMEDA 21239</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>230-05-8339</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. CATHERINE M. MOYER 5010 THE ALAMEDA</b>   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4920  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HASCD</b>       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 76</b> to <b>2-18</b> 19 <b>84</b> , that (I) (we) last<br>saw the deceased alive on <b>2-18</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Ruperto Manankil</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3-20-84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUPERTO MANANKIL</b>   |  |  |  | 22e. ADDRESS<br><b>6010 YORK RD BALTO MD 21212</b>                                   |  |   |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>3/23/84</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LONG GREEN (BALTO.) MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>         |  |                             |  | ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>                         |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 7 2 3 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Sophie</i>                                    |  | FIRST<br><i>Mulcare</i>   |  | MIDDLE<br><i>Mulcare</i>  |  | LAST<br><i>Mulcare</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 9, 1984</i>                      |  | 2b. HOUR<br>M<br><i></i>                     |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>June 16, 1915</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>68</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><i></i>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><i></i>    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>5321 Eastern Ave.</i> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Biker</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i></i> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i></i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>5321 Eastern Ave. 21224</i>                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Michael Novak</i>                          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Frances Szymanski</i>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>       |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-01-5261A</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>James J. Mulcare 7021 Conley Street</i>                          |  |  |  |  |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*1509*

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

*metastases*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>George Karkar</i>  |  |  |  | DEGREE<br><i>M.D. M.A.</i>   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>G. KARKAR</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 22e. ADDRESS<br><i>1576 MERRITT BLVD - suite 9 - BALTO 21222</i>  |  |  |  |  |  |  |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                   |  | 23b. DATE<br><i>3-13-84</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Garden of Faith</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i> |  |
| 24. FUNERAL DIRECTOR<br><i>John M. Weber &amp; Sons Inc. 401 S. Chester St.</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 13 1984</i>          |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randell</i>      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



SECRET

3

SECRET

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county clerk of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked for item 18, shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

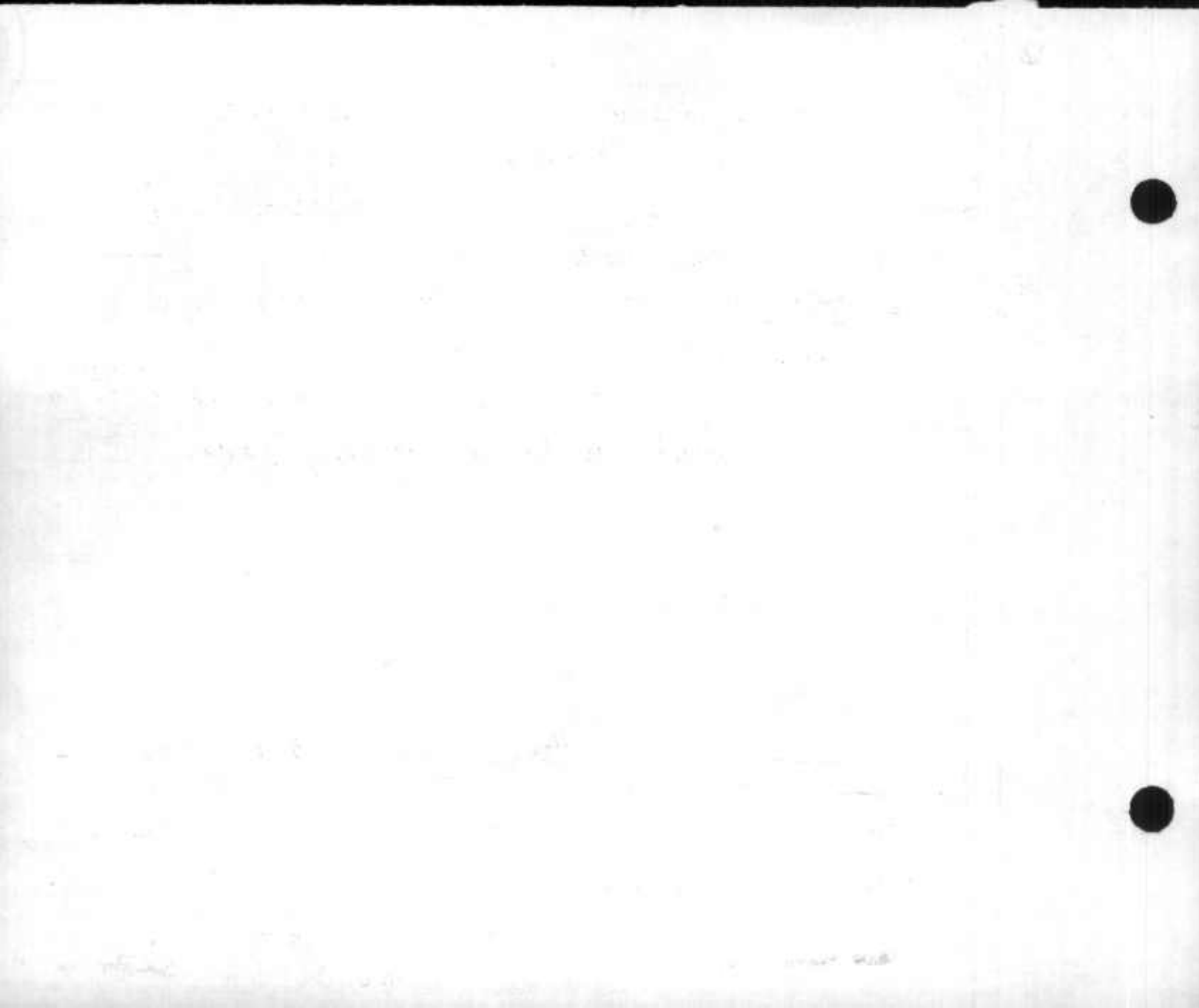
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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |   |  |  |
|---|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy A. Mullaney  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 1, 1984                   |   |   | 2b. HOUR<br>9:15 PM  |   |   |  |  |
| 1. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 20, 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hamilton Nursing Center |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Overlea  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>204 Elinor Avenue 21236  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William David Boyle   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Adams   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-42-4083 |   | 17. INFORMANT<br>ADDRESS<br>21236<br>Mrs. Dorothy Schulze 206 Sipple Ave      |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Artery Disease</i><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>2-20</i> , 19 <i>82</i> , to <i>3-1</i> , 19 <i>84</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>2-20</i> , 19 <i>84</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Marion C. Kowalewski</i>   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>Mar 5, 84                                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marion Kowalewski, M.D.  |  |  |  |   |   | 22e. ADDRESS<br>8604 Harford Road Baltimore, Md.   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Mar 5, 84   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem                       |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Doppel Funeral Homes, Inc.  |  |  |  |   |   | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1984                         |  |  |
|   |  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |  |  |   |  |
|--|--|---|--|---|---|--|--|---|--|
| 1. FOR<br>STATE REGISTRAR<br>ALVIN R. MULLINIX SR.   |  |   |  |   | CERTIFICATE OF DEATH  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH   |  |  |   |  |
| ALVIN R. MULLINIX SR.  |  |   |  |   | 3-11-84 15:40 M P   |  |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>June 23, 1900   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                     |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dairy Manager  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>A.&P. Food Store |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. CITY OR TOWN<br>Catonsville  |  | 13c. STREET ADDRESS<br>1017 Hartmont Road 21228  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Fredmon Mullinix  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose May Ridgley         |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-09-3448  |  | 17. INFORMANT<br>ADDRESS<br>Alvin R. Mullinix Jr. Same as # 13  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u><br>4415<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Hypertension, congestive heart failure, recurrent urinary infections</u>   |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (u) (this hospital) attended the deceased from <u>9/23/79</u> , 19_____, to <u>death</u> , 19_____, that (u) (we) lost saw the deceased alive on <u>3/11/84</u> , 19_____, and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) (did) (did not) view the body after death.             |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Alvin R. Mullinix</u>   |  |   |  | DEGREE<br><u>MD</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>3/11/84</u>                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ALVIN R. MULLINIX</u>  |  |   |  | 22e. ADDRESS<br><u>1001 Pine Heights Ave, Baltimore, MD 21229</u>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>3/14/84</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cemetery</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Md.</u>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</u>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 13 1984</u>                       |  |  |   |  |
| 1630 Edmondson Avenue, Catonsville, Md. 21228  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randell</u>               |  |  |   |  |

WILLIAM R. WILKINSON JR.

WILKINSON JR.

U.S.A.

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Item 4 per pl. 3627/84  
1- STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07236

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Curtis DAVID Mullins</b>                                  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 19 84</b>  |   | 2b. HOUR<br><b>8:00 AM</b>                                      |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 17 14</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALT. GENERAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Boilermaker</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>PRINCE GEORGE</b>   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>20 ST. Agnes Rd. 21061</b> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PATTON Mullins</b>                                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LUCIE Anne Mullins</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |   | 16b. SOCIAL SECURITY NO.<br><b>404-09-6485</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>A. Boeck 50. BALT Gen.</b>       |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory Failure****1850**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Metastatic Prostate G.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

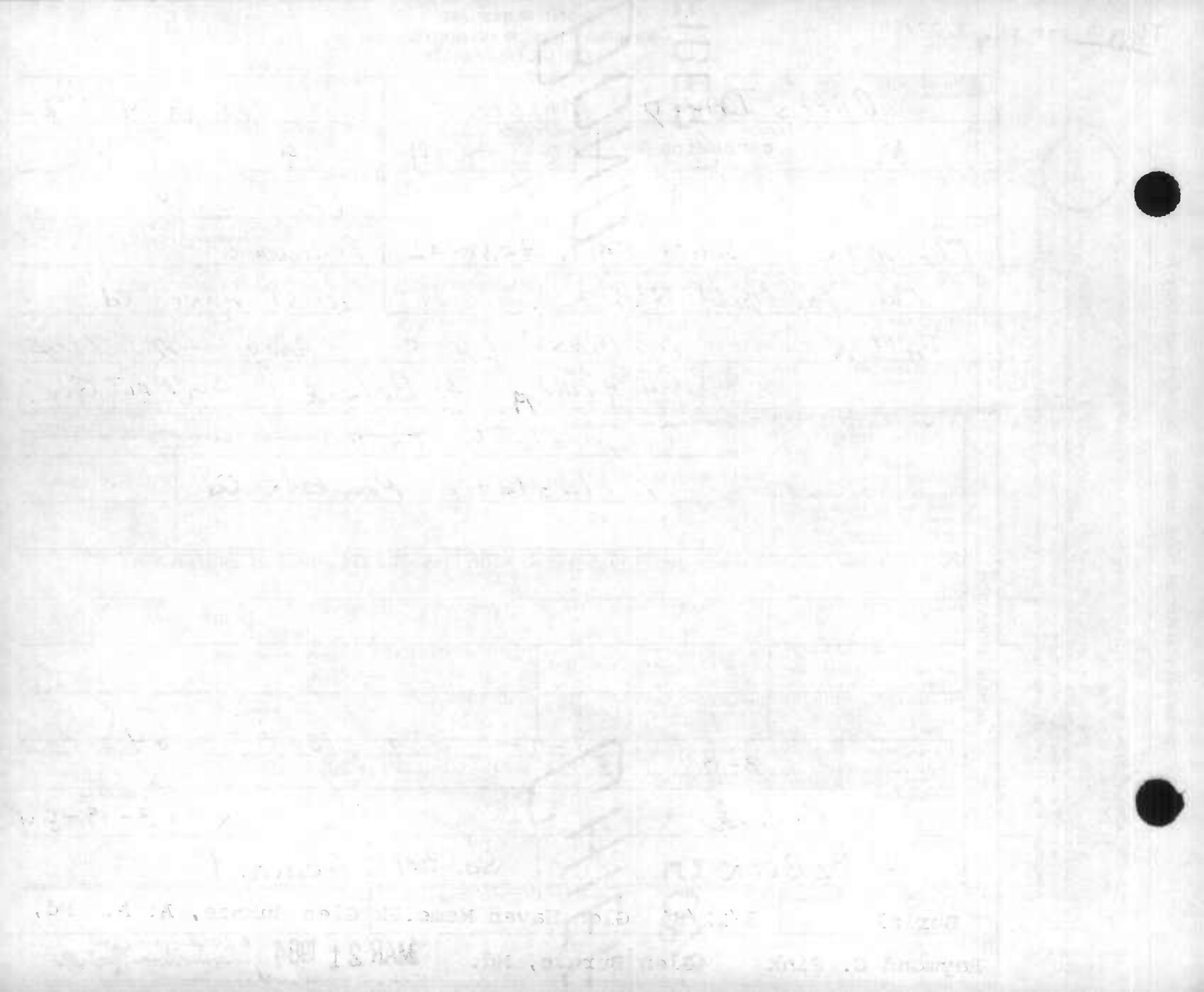
|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-1-84</b> , to <b>3-19-84</b> , that (I) (we) last saw the deceased alive on <b>3-19-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>H. Boeck</b>   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>3-19-84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Boeck</b>  |  | 22e. ADDRESS<br><b>So. BALT. General</b>                                       |  |

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>3/22/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memo. Pk</b> | 23d. LOCATION<br>(CITY OR TOWN)<br><b>Glen Burnie, A. A. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>        |                             | 25. TIME RECD. BY REGISTRAR<br><b>MAR 21 1984</b>                |  |
| ADDRESS<br><b>Glen Burnie, Md.</b>                            |                             | 26. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07237

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Dolores Mary Murphy</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 5, 1984</b>                          |   | 2b. HOUR<br>M<br><b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 24 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.           |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1651 Burnwood Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William J. Steigers</b>                   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice M. McMannas</b>            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>James L. Murphy 1651 Burnwood Road 21239</b> |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carotonia Lary.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>above</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7-83</b><br><b>(9 mos)</b> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

|  |  |   |  |
|--|--|---|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3 84</b>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>17 26</b> 19 <b>83</b> to <b>3</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>above</b> , (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Seymour Weiner</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Seymour Weiner, M.D.</b>   |  | 22e. ADDRESS<br><b>1900 E. Northern Parkway Baltimore, Md.</b>  |  |

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                            | 23b. DATE<br><b>Mar. 7, 1984</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1984</b>          |  |
|  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHIEF IN



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14

Inventory  
Page

5-3-3  
(P)

RELEASED NON MED DR SMITH PER MR GREGOR

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>TINA Nicole MURPHY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03/12/84</b>                               |  | 2b. HOUR<br><b>9:00 pm</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 5 1980</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>3</b> YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>N. Carolina</b>  |  | 13b. COUNTY<br><b>Terrace</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>731 Naha Drive</b> <b>28543</b>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jackie L. Murphy</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Denise A. Durdock</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>415-41-3550</b>  |  | 17. INFORMANT<br><b>Jackie L. Murphy</b> Same as 13e                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>7451</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardiac Surgery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>congenital heart defect</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 minutes</b><br><b>10 hours</b><br><b>Five birth</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/12/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Transposition of the Great Vessels</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , 19 <b>84</b> , to <b>3/12</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>3/12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>David Johnson</b>  |  |   |  | 22c. DATE SIGNED<br><b>3/12/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID JOHNSON</b>   |  |   |  | 22e. ADDRESS<br><b>601 N. Broadway</b><br><b>Johns Hopkins Hospital</b>              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/15/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1984</b>   |  |   |  | 25b. DATE REC'D. BY REGISTRAR<br><b>Johns Hopkins Hospital</b>                       |  |

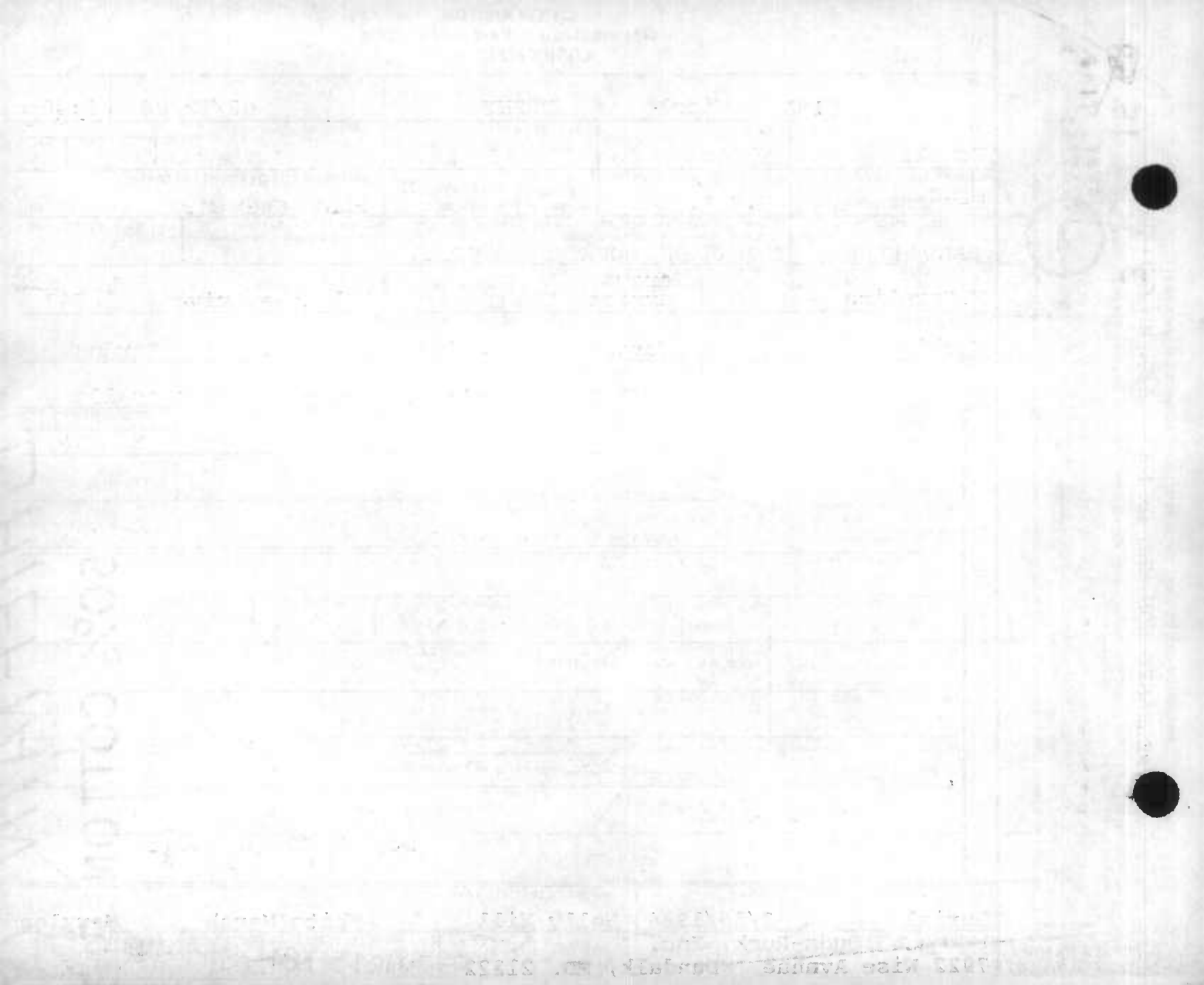
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



Items 18-22a 4/9/84 mtb F4590  
 FOR  
 1- STATE  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
|--|--|--|--|--|--|---|--|---|--|------------------|--|--------------------------------------|--|---|--|---|--|---|--|--------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH  |  | ESTIMATED        |  | MONTH                                |  | DAY                                     |  | YEAR  |  | 2b. HOUR  |  |              |  |
| ALICE  |  |  |  |  |  | MURRAY  |  | 3   |  | 7                |  | 19                                   |  | 84                                      |  |   |  | M   |  |              |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 7c. DATE<br>PRONOUNCED<br>DEAD       |  | MONTH                                   |  | DAY   |  | YEAR  |  | 2d. HOUR     |  |
| Female   |  | Black  |  | 8 7 44   |  | 39 YRS.   |  |   |  |                  |  | 3                                    |  | 7                                       |  | 19  |  | 84  |  | 6:25<br>P.M. |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | NEVER MARRIED   |  | WIDOWED   |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |   |  |   |  |              |  |
| Maryland   |  | U.S.A.   |  |  |  |   |  |   |  |                  |  | Baltimore City                       |  |   |  |   |  |   |  |              |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| Baltimore  |  | Bon Secours Hosp.  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| Maryland   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 205 S. Perry Street 21223   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE  |  | LAST             |  |                                      |  |   |  |   |  |   |  |              |  |
|  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| NO   |  |  |  | 215-36-0879  |  | Solomon Selby   |  | 516 Rosehill Terrace  |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |              |  |
| PART I DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| IMMEDIATE CAUSE (a) <u>Alcoholism</u>  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 3030   |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| (b)  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| (c)  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                |  |   |  |   |  |                  |  |                                      |  |   |  | 20. AUTOPSY?  |  |   |  |              |  |
|  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |              |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19       |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
|  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET   |  |                  |  | CITY OR TOWN                         |  |   |  | COUNTY  |  | STATE   |  |              |  |
|  |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |   |  |                  |  |                                      |  |   |  |   |  |   |  |              |  |
| ACTUAL<br>SIGNATURE  |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER               |  |   |  |   |  |                  |  |                                      |  | DATE<br>SIGNED 3-8-84                   |  |   |  |   |  |              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |  |  | Ann M. Dixon, M.D.   |  |   |  |   |  |                  |  |                                      |  | ADDRESS 111 Penn St., Balto., Md. 21201 |  |   |  |   |  |              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION<br>CITY OR TOWN        |  |   |  | COUNTY  |  | STATE   |  |              |  |
| BURIAL   |  |  |  | 3/15/84  |  |   |  | Mount Zion Cemetery   |  |                  |  | Lansdowne,                           |  |   |  |   |  | Md.   |  |              |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |  | ADDRESS  |  |   |  |   |  |                  |  |                                      |  | 25a. DATE                               |  |   |  | BY REGISTRAR 25b. REGISTRAR'S SIGNATURE         |  |              |  |
| Wm C March F/H Inc.  |  |  |  | 1101 E North Avenue  |  |   |  |   |  |                  |  |                                      |  | MAR 15 1984                             |  |   |  | Julia Davidson                                  |  |              |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEMORANDUM FOR THE DIRECTOR  
FROM THE SECRETARY  
SUBJECT: [illegible]

REBIF NOTTO

END

204

Handwritten notes at the bottom left corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a medical investigation will be conducted.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |  |   | REG. NO. 07240  |                                   |
|--|---|--|---|---|-----------------------------------|
| 1- FOR STATE REGISTRAR SONIA D. MURRILL  |   | 2a. DATE OF DEATH  |   | 3 9 84  |                                   |
| 1. DECEASED NAME (TYPE OR PRINT) SONIA D. MURRILL  |   | 2b. HOUR 3:48A M   |   |   |                                   |
| 3. SEX FEMALE  | 4. RACE CAUCASIAN   | 5. DATE OF BIRTH 7 23 02   |   | 6. AGE (IN YEARS LAST BIRTHDAY) 81  |                                   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.   | 7b. CITIZEN OF WHAT COUNTRY? USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.                           |                                   |
| 10. CITY OR TOWN OF DEATH BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND  |   | 13b. COUNTY ANN ARUNDEL  | 13c. CITY OR TOWN PASADENA                                    | 13d. STREET ADDRESS / ZIP CODE 306 DORCHESTER RD 21122                            |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST MARTIN OSKOWICZ  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE ZEMBA  |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO. 216-09-9683   |   | 17. INFORMANT ADDRESS Vera Pazdersky (same as 13e)                                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4280 Acute respiratory failure follow by cardiac arrest.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Severe diffuse pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c) Super imposed CHF Septic prob. ARDS |   |  |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |   |  |   |   |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (his hospita) attended the deceased from 3-9-84 to 3-9-84, that (I) (we) lost saw the deceased alive on 3-9-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |   |  |   |   |                                   |
| 22b. SIGNATURE Edwin E. Pagan MD.  |   | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin E. Pagan   |   | 22e. ADDRESS 3001 South Avenue 2 Baltimore Md.   |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL Burial   |   | 23b. DATE 3/12/84  |   | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery                             |                                   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.  |   | 23e. DATE REC'D. BY REGISTRAR  |   | 23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall                                 |                                   |
| 24. FUNERAL DIRECTOR Baltimore, Md. 21225 George J. Gonce F.H. 4001 Ritchie Hwy.   |   | 25a. DATE REC'D. BY REGISTRAR  |   |   |                                   |



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NOV 19 1964

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C. 20250

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20250

TELEPHONE (202) 725-6000

TELETYPE (202) 725-6000

FACSIMILE (202) 725-6000

MAIL ROOM (202) 725-6000

RECORDS MANAGEMENT (202) 725-6000

GENERAL INVESTIGATIVE DIVISION

WASHINGTON, D.C. 20250

TELEPHONE (202) 725-6000

TELETYPE (202) 725-6000

FACSIMILE (202) 725-6000

MAIL ROOM (202) 725-6000

RECORDS MANAGEMENT (202) 725-6000

GENERAL INVESTIGATIVE DIVISION

EXHIBITION

GENERAL INVESTIGATION

WASHINGTON, D.C. 20250

TELEPHONE

NOV 19 1964

TELETYPE (202) 725-6000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07241

|  |   |  |   |   |
|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAZEL B MYERS</b>   |   | 2a. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>08</b> YEAR <b>84</b>  |   | 2b. HOUR<br><b>12:30 PM</b>   |
| 1. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>23</b> YEAR <b>1918</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                           |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.           |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>                      |
| 13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>MD.</b> 13c. COUNTY <b>Balto.</b> 13d. CITY OR TOWN <b>Balto.</b> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>872 Washington Blvd. 21230</b>  |   |   |
| 14. FATHER'S NAME<br><b>John Henry Wills</b>   |   | 15. MOTHER'S MAIDEN NAME<br><b>Sara Lam</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>-</b>   |   | 17. INFORMANT ADDRESS<br><b>Dolores Wills - 1172 Washington Blvd. 21230</b> |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cancer of lung i metastases**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **COPD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> 19 <b>83</b> , to <b>3/8</b> 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/8</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Kuang-yen Huang</b>  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/8/84</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  | 22e. ADDRESS<br><b>BON Secours Hospital</b>  |  |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                     | 23b. DATE<br><b>3/12/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Elk Run Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN <b>Elkton</b> COUNTY <b>Rockingham</b> STATE <b>Va.</b> |
| 24. FUNERAL DIRECTOR<br><b>John J. Cowan &amp; Son, Inc. 901 Hollins St. Baltimore, Md. 21223</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b>           |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                      |  |
|---|--|--|---|---|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE ELIZABETH LAST MYERS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 22 84 |   | 2b. HOUR<br>11 30 PM |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 11 89  |                      |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br>74 YRS   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.  |   | 8. CITIZEN OF WHAT COUNTRY?<br>USA  |                      |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South BALTIMORE General            |                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |   | 13. STREET ADDRESS / ZIP CODE<br>226 HAZEL Avenue 21227   |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert T. DOBSON  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Moran  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |                      |  |
| 16b. SOCIAL SECURITY NO.<br>212-76-0437   |  | 17. INFORMANT<br>WALTER R. MYERS   |   | ADDRESS<br>226 HAZEL AVENUE, 21227  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>5188<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>INTERSTITIAL Lung Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |   |   |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                      |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                      |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>3-15</u> , 19 <u>84</u> , to <u>3-22-84</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |                      |  |
| 22b. SIGNATURE<br><u>H. Bubeck</u>  |  | DEGREE   |   | 22c. DATE SIGNED<br>3-22-84   |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. BUBECK  |  | 22e. ADDRESS<br>SOUTH BALT. GENERAL HOSP   |   | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>03-26-84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL   |                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND   |  | 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1984  |                      |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |   |   |                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, it is to be filed with the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAR 78 9AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary S. Nance</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>March 6 '84</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>BIK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7 27 30</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>2709 W. Harlem Avenue</b><br><b>Baltimore, Maryland 21216</b>                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Stroud</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pearl Holtz</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-38-2411</b>  |  | 17. INFORMANT<br>ADDRESS <b>2709 W. Harlem Ave.</b><br><b>Thomas Nance Baltimore, Maryland 21216</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Broncho pneumonia</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> 19 <b>84</b> to <b>4/6</b> 19 <b>84</b> that (I) (we) lost<br>saw the deceased alive on <b>4/6</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cheng-Chung Lin</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/6/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHENG-CHUNG LIN</b>  |  | 22e. ADDRESS<br><b>Lutheran Hospital of Maryland</b><br><b>Baltimore, Md 21216</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/11/1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Nutter &amp; Sons Funeral Home Inc.</b><br><b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 9 1984</b><br>REGISTRAR'S SIGNATURE<br><b>J. H. Anderson-Randall</b>  |  |  |  |



|                           |                           |                           |
|---------------------------|---------------------------|---------------------------|
| U. S. A.                  | U. S. A.                  | U. S. A.                  |
| Baltimore                 | Baltimore                 | Baltimore                 |
| 2702 N. Harbor Ave.       | 2702 N. Harbor Ave.       | 2702 N. Harbor Ave.       |
| Baltimore, Maryland 21216 | Baltimore, Maryland 21216 | Baltimore, Maryland 21216 |
| No.                       | No.                       | No.                       |

2028 COLTON



2701 N. Harbor Ave. Baltimore, Md. 21216  
 Walter & Sons General Home Inc.  
 1/11/1968  
 Baltimore, Maryland



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |   |  |   |   |  | REG. NO. |  |
|---|-------------------------|---|---|---|---|--|---|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Theodore</b> <b>Nawarynski</b>   |                         |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3/12/84</b> |   | 2b. HOUR <b>10:15</b>   |  |          |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 20 1902</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>81</b> YRS.               | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br><b>3/12/84</b>                                    | 7d. HOUR <b>A</b>  |   |   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ukraine</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Ukraine</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |   |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1928 Bank Street</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitorial Service</b>             |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |   | 13e. STREET ADDRESS<br><b>1928 Bank Street 21231</b>                                |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> <b>-</b> <b>Nawarynski</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> <b>-</b> <b>Unknown ?</b>   |   |  |   |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |                         |   |   | 16b. SOCIAL SECURITY NO.<br><b>216-32-8964</b>  |   | 17. INFORMANT ADDRESS<br><b>Andrew Nawarynski 213 Elinor Ave. 21206</b>                                |   |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Cirrhosis of liver due to chronic alcoholism, Coronary Obstruc. Pulmonary Disease</b>   |                         |   |   |   |   |  |   |   |  |          |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |  |   |   |  |          |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |                         |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                          |   |   | MEDICAL EXAMINER   |   | DATE SIGNED <b>3/12/84</b>  |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                         |   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                    |   |   |  |   |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>Mar. 14 1984</b>                                  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Michael Ukrainian Cen.</b>       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler, Inc. 4001 Eastern Ave. 21231</b>   |                         |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1984</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>             |   |  |          |  |

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DIVISION OF VITAL RECORDS, 201 W. GRESTON ST., BALTIMORE, MARYLAND 21201

HAZELROD, GLADYS H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the body be secured within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 with any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 07245   |  |   |  |
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GLADYS NAZELROD</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 15, 1984</b>  |  | 2b. HOUR<br><b>10:55 AM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 14 23</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cashier</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rite Aid Drug</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert C. McDonald</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flossie Duncan</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>236-20-9688</b>   |  | 17. INFORMANT ADDRESS<br><b>Sheila Phillips 708 S. Dean Street</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1830</b><br>IMMEDIATE CAUSE (a) <b>Respiratory and Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>multisystem Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ovarian Carcinoma</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3/15/84</b><br><b>1983</b> } 2yr<br><b>1982</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a)<br><b>Aspiration of Vomitus</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b>  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>84</b> , to <b>3/15</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>C. A. Davis</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/15/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Cee A Davis</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital, Baltimore, MD</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-19-84</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn A.A. Co. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Zeiler &amp; Son Inc.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

072486

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>First: Evelyn C. Last: Ness  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03-10-84   |  | 2b. HOUR<br>17:58 P  |
| 3. SEX<br>F   | 4. RACE<br>W   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 18 35  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. 21201 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>3540 Keswick Rd 21211                              |  |
| 14. FATHER'S NAME<br>First: Thomas Middle: Davis  |  | 15. MOTHER'S MAIDEN NAME<br>First: Florence Middle: Burke Last: Burke   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218-32-9162   |   | 17. INFORMANT<br>Address: 3540 Keswick Road 21211<br>Name: Mr. Franklin Ness         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4180 Cardiogenic Shock<br>DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Probable Acute M.I.                               |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Months<br>~12-24°  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 02-29-84, 19 to 03-10-84, 19 84, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>Stephen Lincoln M.D.  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>03-10-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen Lincoln M.D.   |  | 22e. ADDRESS<br>22 So. Greene St., Baltimore, MD. 21222   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>3/14/84   | 23c. NAME OF CEMETERY OR CREMATORY<br>Crest Lawn Gardens  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr. 3818 Roland Avenue 21211   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1984  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

LIBRARY

10/10/1950

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Aug 21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy parts, Pages 1 and 2, and place them in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOHN Joseph NEUBAUER Sr.   |  |  |  | 2a. DATE OF DEATH<br>3 13 84 6:25 PM  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Aug. 3, 1933  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Balto. City Police Dept.  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br>5308 Tramore Rd. 21214   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick J. Neubauer  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie A. Bateman   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes Korean  |  |
| 16b. SOCIAL SECURITY NO.<br>213-30-8546  |  | 17. INFORMANT<br>John J. Neubauer, Jr.   |  | ADDRESS<br>Same as # 13e  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>4301<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>intracerebral/subarachnoid hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ant. communicating aneurysm</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min<br>9 days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>M1 Hypertension  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>6 P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from 3/4, 19 84, to 3/13, 19 84, that (I) (we) saw the deceased alive on 3/13, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Margaret Vaughan<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/><br>22c. DATE SIGNED<br>3/13/84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARGARET VAUGHAN MD   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3-17-84  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md.  |  | 25a. DATE REC'D BY REGISTRAR<br>MAR 14 1984   |  |





5310  
MSA/3/63/13/71

Leonard J. Luck, Inc. Baltimore, Md.  
Baltimore Valley  
Baltimore, Maryland

3-17-64  
3/10/64  
X

Frederick J. Neubauer  
John J. Neubauer, Jr. Same as above  
A.  
Baltimore

Marland  
Baltimore  
X  
308 Fremont Rd. Baltimore  
Baltimore City Police Dept.

Male  
White  
Aug. 2, 1933  
St. Joseph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KARL NEWELL</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 8 84</b><br>2b. HOUR<br><b>1230 PM</b> |  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 26 99</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                     |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Minister</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Lutherville</b>   |  | 13c. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>#6 Nightingale Way 21093</b>                    |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alphonse M. Newell</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline Rey</b>               |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-8448</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Ruth D. Newell - Same as #13.</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Congestive Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 month</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1 month</b> |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2 15 84</b> to <b>3 8 84</b> , that (I) (we) lost saw the deceased alive on <b>3 8 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Wm H Copeland MD</b>  |  |   |  |   | DEGREE<br><b>MD</b>  |  |   | 22c. DATE SIGNED<br><b>3 8 84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm H Copeland MD</b>   |  |   |  |   | 22e. ADDRESS<br><b>201 E. UNIVERSITY PARKWAY</b>                                   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |   | 23b. DATE<br><b>3/8/84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |  |   | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1984</b> |  |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                        |  |   |  |  |

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1. Name of the plant or animal: *...*

2. Name of the collector: *...*

3. Date of collection: *...*

4. Locality: *...*

5. Description of the specimen: *...*

6. Remarks: *...*

7. Name of the collector: *...*

8. Date of collection: *...*

9. Locality: *...*

10. Description of the specimen: *...*

11. Remarks: *...*

12. Name of the collector: *...*

13. Date of collection: *...*

14. Locality: *...*

15. Description of the specimen: *...*

16. Remarks: *...*

17. Name of the collector: *...*

18. Date of collection: *...*

19. Locality: *...*

20. Description of the specimen: *...*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <i>Mervin</i> MIDDLE <i>Bradley</i> LAST <i>Newman</i><br><b>MERVIN BRADLEY NEWMAN</b>   |  | 2a. DATE OF DEATH<br>MONTH <i>3</i> DAY <i>19</i> YEAR <i>84</i><br><b>3/19/84</b>  |  | 2b. HOUR<br><i>6:50</i> P.<br><b>6:50 P.</b>  |  |
| 3. SEX<br><i>Male</i><br><b>Male</b>  |  | 4. RACE<br><i>White</i><br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <i>4</i> DAY <i>26</i> YEAR <i>01</i><br><b>4/26/01</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i><br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i><br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i><br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>North Charles St. Gen. Hospital</i><br><b>North Charles St. Gen. Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i><br><b>Baltimore City</b> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i><br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Chauffeur</i><br><b>Chauffeur</b>   |  |   |  |
| 13a. STATE<br><i>Maryland</i><br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><i>Baltimore</i><br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST <i>William</i> MIDDLE <i>Newman</i> LAST <i>Newman</i><br><b>William Newman Newman</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Mintie</i> MIDDLE <i>Daughtry</i> LAST <i>Daughtry</i><br><b>Mintie Daughtry Daughtry</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i><br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><i>227-05-4221</i><br><b>227-05-4221</b>  |  | 17. INFORMANT<br>ADDRESS<br><i>Amanda E. Newman 3029 E. Baltimore St.</i><br><b>Amanda E. Newman 3029 E. Baltimore St.</b>                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>POSSIBLE LUNG CARCINOMA &amp; METASTASIS</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>MALNUTRITION</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10: PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/6</i> 19 <i>84</i> to <i>3/19</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>3/19</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>A.C. Chouvalit, M.D.</i><br><b>A.C. CHOUVALIT, M.D.</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><i>3/19/84</i><br><b>3/19/84</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A.C. CHOUVALIT, M.D.</i><br><b>A.C. CHOUVALIT, M.D.</b>   |  | 22e. ADDRESS<br><i>NORTH CHARLES GEN. HOSP.</i><br><b>NORTH CHARLES GEN. HOSP.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i><br><b>Burial</b>  |  | 23b. DATE<br><i>3-22-84</i><br><b>3-22-84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart Cem.</i><br><b>Sacred Heart Cem.</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dundalk, Baltimore Co., Md.</i><br><b>Dundalk, Baltimore Co., Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</i><br><b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b>                                |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i><br><b>[Signature]</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

| Item 11 & 13 athru e Item 4   |  |   |  |   |   |   |                                       |   |   | STATE OF MARYLAND  |  |  |
|---|--|---|--|---|---|---|---------------------------------------|---|---|--|--|--|
| 1. STATE phone 3-22-84 cn   |  |   |  |   |   |   |                                       |   |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |
| REGISTRAR   |  |   |  |   |   |   |                                       |   |   | CERTIFICATE OF DEATH   |  |  |
| REG. NO.  |  |   |  |   |   |   |                                       |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILFRED</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>12</b> YEAR <b>84</b>      |   |                                       |   |   | 2b. HOUR<br>M  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>18</b> YEAR <b>1887</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.                                   |                                       | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                            |   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO City</b> MD.                       |                                       |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Penna Ave. N.H.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WATCHMAN</b> |                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>                                       |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b> |   |                                       |   |   | 13e. STREET ADDRESS<br><b>607 Pennsylvania Ave 21201</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT   |                                       |   | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adeno Carcinoma of Colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |   |   |                                       |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 years</b><br><b>2</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Anemia, CVA &amp; Hemiplegia, CBS, ASD</b>   |  |   |  |   |   |   |                                       |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |                                       |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |                                       |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-13-1969</b> to <b>3-12-1984</b> , that (I) (we) lost saw the deceased alive on <b>3-12-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |                                       |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Shaukat Y. Khan M.D.</b>   |  |   |  |   |   |   |                                       | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3-13-84</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHAUKAT Y. KHAN M.D.</b>  |  |   |  |   |   |   |                                       | 22e. ADDRESS<br><b>1528 King William Drive, Balto, MD</b>                 |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE<br><b>3-23-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                             |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>21228</b>                |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Dr. P. Carroll</b> ADDRESS <b>1712 W. North</b>   |  |   |  |   |   |   |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1984</b>                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |  |



BOA COLONIA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

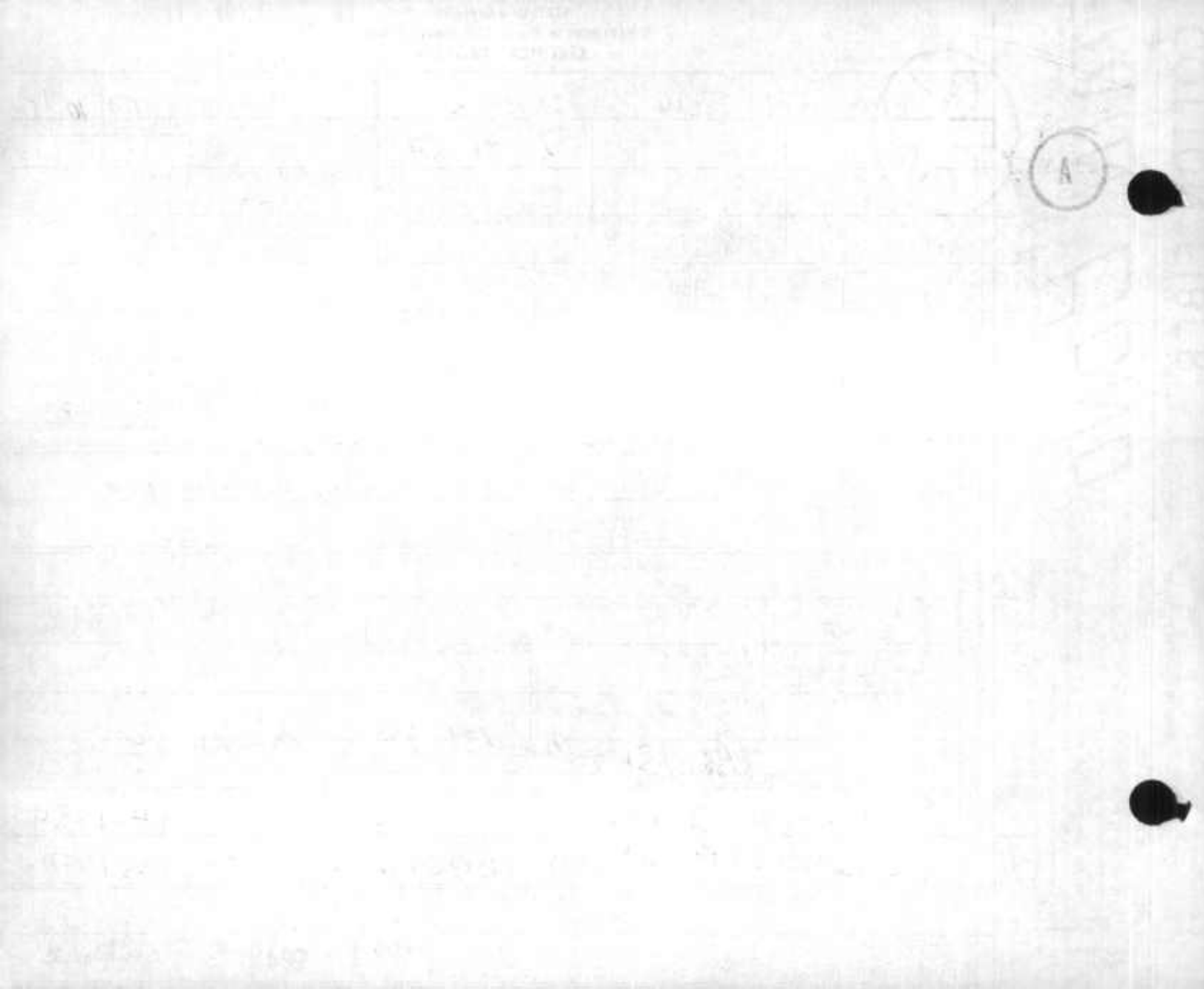
BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BABY GIRL ZELMA NICKEN  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 31, 1984 |   |  | 2b. HOUR<br>10:30 P.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 31 84   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>20 19   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Infant  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Frederick   |   | 13c. CITY OR TOWN<br>Frederick  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ronald Alvin Lewis   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Zelma Jean Nickens  |   | 16. ADDRESS<br>3133 Flint Hill Road<br>Mildred Onley, Adamstown, Md. 21710  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none  |   | 17. INFORMANT<br>Mildred Onley, Adamstown, Md. 21710  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>7718<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>PREMATURITY, WITH HYALINE MEMBRANE DISEASE.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFECTION.</u> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br>NONE   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 31, 1984</u> to <u>March 31, 1984</u> , that (I) (we) last saw the deceased alive on <u>March 31, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u> MD  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>4-1-84   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B.C. BARTLETT JR MD   |  |  |   | 22e. ADDRESS<br>BALTIMORE CITY 165 PIM  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4/4/84  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunnyside Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sunnyside, Frederick, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Douglas Stauffer, Frederick, Md. 21701  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br>APR 10 1984   |  |  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

MEDICAL CERTIFICATION



Items #18-22a 4/4/84 mtb F#590

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

0 7 2 5 2

FOR  
1- STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                  |   |   |   |   |   |   |  |
|---|------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William T. Nies  |                  |   | 2a. DATE KNOWN OF DEATH<br>EST. MATED <input checked="" type="checkbox"/> 3/2/84 19 |   |   | 2b. HOUR<br>M 5:25 P  |   |  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 26 1920  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>63 YRS.                                       | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3/11/84 19              | 2d. HOUR<br>P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD             |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Rear of 2315 Montebello Terr. |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2807 Louise Ave. 21214                         |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Nies   |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Townsend                   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-09-9430  |   | 17. INFORMANT ADDRESS<br>Henry A. Nies 4311 Kolb Ave. 21206   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                     |                  |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Pneumonia</u>   |                  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above; held in death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>TITLE (SPECIFY)<br>M. Dep. Chief MEDICAL EXAMINER<br>DATE SIGNED 3/12/84 |                  |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith   |                  | EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St., Balto., Md. 21201   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>Mar. 14, 1984  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md.  |                  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1984  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



ONE MIN

REBEL NOT TO

*Handwritten signature or initials.*



4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

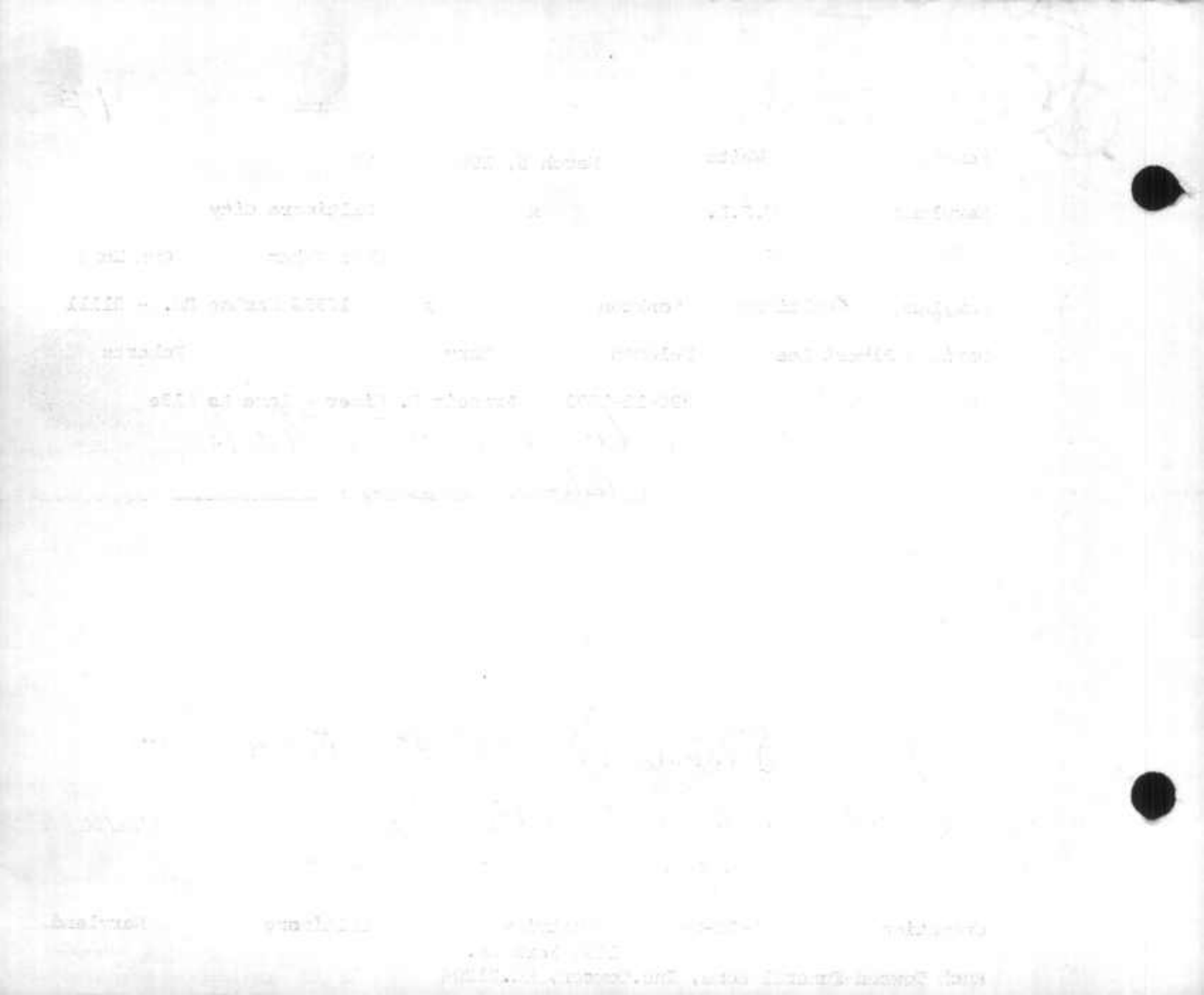
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |   |   |   |  |   |  |
|--|--|---|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUCILLE V. NINER</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 21, 1984</b>                     |   | 2b. HOUR MIN.<br><b>1:40 PM</b>                       |   |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 5, 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Center</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Monkton</b>                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>16335 Markoe Rd. - 21111</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Albert Lee Feldman</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Roberts</b>          |   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-12-7371</b> |   |   | 17. INFORMANT<br>ADDRESS<br><b>Francis R. Niner - Same As #13e</b>                    |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b): <b>Acute heart attack</b><br>DUE TO, OR AS A CONSEQUENCE OF (c): <b>Coronary atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8 PM 19 84</b>          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(ENT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8 March 19 84</b> to <b>March 21 19 84</b> , that (I) (we) last saw the deceased alive on <b>8 March 19 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |   |  |   |  |
| 22a. SIGNATURE<br><b>William G. Helfrich MD</b>  |  |   |   |   |   | 22b. ADDRESS<br><b>5006 Roland Avenue</b>   |   | 22c. DATE SIGNED<br><b>3/21/84</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>3-22-84</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1984</b>                                   |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |   |   |   |   |   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07254

1. FOR STATE REGISTRAR **GERALD F. NOONAN**

REG. NO.

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GERALD F. Noonan</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>03-08-84</b>                    |   |  | 2b. HOUR<br><b>01:50 A M</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>04 28 27</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balti.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Md.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BANKING</b>                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> |  | 13b. COUNTY <b>Anne Arundel</b>   |  | 13c. CITY OR TOWN <b>Pasadena</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8472 Main Ave. Pasadena Md. 21122</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robt. Noonan</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE KOESTERS</b> |   |  |   |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE SERVICE)<br><b>YES</b>                                   |  | 16b. SOCIAL SECURITY NO.<br><b>W W H 219-22-3879</b>  |  | 17. INFORMANT ADDRESS<br><b>Marie Noonan (same as 13e)</b>  |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4140**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

**03-06-84**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**Coronary Atherosclerosis**

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **03-04**, 19 **84**, to **03-08**, 19 **84**, that (I) (we) last saw the deceased alive on **03-08-84**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

**03-08-84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**Stephen Lincoln M.D.****22 So. Greene St., Balt., Md. 21201**

23a. BURIAL, CREMATION, REMOVAL

**Burial**

23b. DATE

**3/12/84**

23c. NAME OF CEMETERY OR CREMATORY

**Glen Haven Memorial**

23d. LOCATION CITY OR TOWN

**Glen Burnie**

COUNTY

**A.A.**

STATE

**Md.**24. FUNERAL DIRECTOR **Baltimore, Md. 21225**

NAME

ADDRESS

**George J. Gonce F.H. 4001 Ritchie Hwy.**

25a. DATE REC'D. BY REGISTRAR

**MAR 13 1984**

25b. REGISTRAR'S SIGNATURE

**John Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



01-20-10

01-20-10

01-20-10

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01-20-10

CITY

01-20-10

01-20-10

01-20-10

University of Md.

01-20-10

01-20-10

01-20-10

01-20-10

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01-20-10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |         |   |        |   |                |   |  |         |
|--|---------|---|--------|---|----------------|---|--|---------|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH   |        | MONTH   | DAY            | YEAR  | 2b. HOUR                                     |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   | MIDDLE | LAST  |                |   |  |         |
| JOHN   |         | NORMAN  |        |   | MARCH 26, 1984 |   |  | 5:45 pm |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |                | IF UNDER 1 YEAR   |  |         |
| MALE   | NEGROID | MONTH DAY YEAR<br>Mar. 9, 1912  |        | 72  |                | IF UNDER 24 HRS.  |  |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |         |
| S. C.  |         | U.S.A.  |        |   |                | Balto. City MD  |  |         |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |         |
| Balto.   |         | Church Hosp.  |        | Retired   |                | Industry  |  |         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                | 13d. INSIDE CITY LIMITS?  |  |         |
| 13a. STATE   |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                | 13d. INSIDE CITY LIMITS?  |  |         |
| MD.  |         |   |        | Balto.  |                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |         |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |        | 13e. STREET ADDRESS   |                |   |  |         |
| FIRST MIDDLE LAST  |         | FIRST MIDDLE LAST   |        | 904 N. Castle St.   |                |   |  |         |
| Robert   |         | Norman  |        | Annie Geter   |                |   |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |        | 17. INFORMANT   |                | ADDRESS   |  |         |
| NO   |         | 577-14-9887   |        | Alice Norman  |                | 904 N. Castle St.   |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>1550<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>HEPATOMA HEPATIC DECOMPENSATION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HIGH BLOOD PRESURE CONGESTIVE HEART FAILURE</u> |         |   |        |   |                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |         |   |        |   |                |   |  |         |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |         |
|  |         |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                |   |  |         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                |   |  |         |
|  |         |   |        |   |                |   |  |         |
| 22a. I certify that (I [he] this hospital) attended the deceased from FEB 29, 19 84, to MAR. 26, 19 84, that (I [we] last saw the deceased alive on MAR. 26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I [we] did) (did not) view the body after death.   |         |   |        |   |                |   |  |         |
| 22b. SIGNATURE   |         |   |        | DEGREE  |                | 22c. DATE SIGNED  |  |         |
| MUKESH LUHAR MD  |         |   |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |                |   |  |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         |   |        | 22e. ADDRESS  |                |   |  |         |
| Mukesh B. Luhar  |         |   |        | CHURCH HOSPITAL<br>100 N. BROADWAY BALTO. MD 21231  |                |   |  |         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |         |
| Burial   |         | 3-31-84   |        | Mt. Calvary Cem.  |                | Anne Arundel County, Md.  |  |         |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |   |        | 25a. DATE REC'D. BY REGISTRAR   |                | 25b. REGISTRAR'S SIGNATURE  |  |         |
| Calvin B. Scruggs 1412 E. Pres   |         |   |        | MAR 28 1984   |                | Julia Davidson-Randall  |  |         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes and signatures are visible across the page, including a large signature in the lower right quadrant.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as significant, show any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Thomas</i> MIDDLE <i>Frank</i> LAST <i>Novak</i>   |  |   |   |
| 2. DATE OF DEATH MONTH <i>3</i> DAY <i>29</i> YEAR <i>84</i>   |  |  |  | 2b. HOUR <i>8:30</i> P.M.  |  |   |   |
| 3. SEX <i>Male</i>   |  | 4. RACE <i>White</i>   |  | 5. DATE OF BIRTH MONTH <i>12</i> DAY <i>14</i> YEAR <i>96</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.  |   |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Seaman</i>   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. STREET ADDRESS  |  |   |   |
| 13a. STATE <i>Maryland</i>   |  | 13b. COUNTY <i>---</i>   |  | 13c. CITY OR TOWN <i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST <i>Frank</i> MIDDLE <i>---</i> LAST <i>Novak</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <i>Catherine</i> MIDDLE <i>Rybarczyk</i> LAST <i>---</i>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>W.W. I</i>   |  | 17. INFORMANT ADDRESS <i>Lillian A. Novak 605 S. Rappolla Street</i>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CLVA</i>  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 min</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>1 month</i>  |  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/28</i> 19 <i>83</i> , to <i>3/29</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>3/29</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |
| 22b. SIGNATURE <i>TV Parran Jr</i>   |  | DEGREE <i>MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c. DATE SIGNED <i>3/30/84</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PARRAN</i>  |  | 22e. ADDRESS <i>BCHH dept of med.</i>  |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | 23b. DATE <i>4-2-84</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem.</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City, Maryland</i>   |   |
| 24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i> ADDRESS <i>901 S. Conkling St.</i>   |  |  |  | 25. DATE REC'D. BY REGISTRAR <i>APR 2 - 1984</i> REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>   |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | REG. NO.                    |  |  |
|---|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Henry C. Nutt</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3/17/84</b> |   | 2b. HOUR<br><b>10:45 PM</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 6 16</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry C. Nutt</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna R. Rich</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>Yes</b>  |                             |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>215-28-8095</b>  |  | 17. INFORMANT ADDRESS<br><b>Alice Sorrell 2423 Annor Ct.</b>  |  |   |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia &amp; Sepsis</b><br><b>4860</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Sepsis as above</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |                             |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |  |
| 22a. I certify that, (I) (this hospital) attended the deceased from <b>03/05/84</b> , 19____, to <b>03/17/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>03/17/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |                             |  |  |
| 22b. SIGNATURE<br><b>S. S. S. M. Anoka</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                             | 22c. DATE SIGNED<br><b>3/17/84</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/22/84</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave,</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1984</b>   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>  |  |

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TO HOSPITAL OR EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                                    |
|---|--|--|--|---|--|---|--|--|------------------------------------|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO. 7 2 5 8   |   |  |  |                                    |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ralph H. Nutter</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 08 84</b>                   |   | 2b. HOUR<br><b>22pm</b>  |  |                                    |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 19 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |  |  |                                    |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Skilledman Hospital, N. J.</b>   |                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |                                    |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2908 Garrison Blvd. Apt. 2 T Baltimore, Md. 21216</b>  |                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ralph G. Nutter</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise E. Parker</b> |   |  |  |                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-12-3738</b>                           |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Herbert E. Nutter &amp; Alice E. Nutter 2908 Garrison Blvd. 21216</b>                                  |  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539 CARCINOMA OF THE LUNG WITH METASTASIS</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |                                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/21 1984</b> to <b>03/08 1984</b> , that (I) (we) last saw the deceased alive on <b>03/18 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |                                    |
| 22b. SIGNATURE<br><b>Emeka Okereke</b>  |  |  |  |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/08/84</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EMEKA OKEREKE</b>   |  |  |  |   | 22e. ADDRESS<br><b>2600 LIBERTY HTS</b>                                  |   |  |  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/13/1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |  |                                    |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. Md. 21216</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1984</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |                                    |

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